BCN Provider *News*

2023 *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.

Note:

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

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 2023

BCN Provider News

Farewell, web-DENIS; Hello, Availity Essentials

What you need to know

The last day to log in to Provider Secured Services and web-DENIS was Dec. 15. Make sure you're registered and ready to use Blue Cross and BCN's new provider portal, Availity Essentials.

As we announced in the **November-December issue**, beginning Dec. 16, you'll no longer be able to log in to Provider Secured Services or web-DENIS.

If you're new to Availity® Essentials or if you'd like to brush up on how to best use the tools in our new provider portal, you can register for webinars and view recordings of prior webinars on the **Get Up to Speed with Training** website.

Tip: When you need help using our new provider portal, your first step should be to call 1-800-AVAILITY (282-4548). Help is available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding holidays). When you call, ask for an Availity Client Services, or ACS, ticket number. This number is helpful if the call doesn't resolve your problem and follow-up assistance is needed.

Want to know what's new on our provider portal?

Check out the *Provider Portal Change and Status Updates* document for new provider portal improvements, features and functionality, and issues we're working to address. Here's how to find it:

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

1. Click on *Payer Spaces* on the menu bar, and then click on the BCBSM and BCN logo.
2. Click on the *News and Announcements* tab.
3. Click on *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 if there are any changes to the date listed in this article.

Please see Farewell, web-DENIS; Hello, Availity Essentials continued on Page 2

Inside this issue…

Feedback | Subscribe

Network Operations

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.

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

- Provider alert: **Eligibility and benefits functionality retires from web-DENIS on Nov. 18**
- November-December *BCN Provider News* article: **Final Provider Secured Services and web-DENIS retirement dates announced along with Availity enhancements**

Read the November-December *BCN Provider News* article for earlier retirement notices.

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). Request an ACS ticket number for reference in case this call doesn't resolve your problem and follow-up assistance is needed.

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

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Follow these tips for checking eligibility and benefits in Availity

To get started checking eligibility and benefits on our new provider portal, Availity® Essentials, simply click on *Patient Registration* at the top of your Availity home screen. Then select *Eligibility and Benefits Inquiry*. Here are some tips.

- **Select a patient** — When you're looking for a patient, click on the *Patient Search Option* drop-down menu for a choice of search options. One option is the patient's first and last name, and date of birth.
- **Active and inactive contracts** — Active contracts have a green bar; inactive contracts have a red bar.
- **If a patient's plan is inactive** — Here are two actions you can take if you find that a patient's plan is inactive.
  - A Patient ID in Availity is the patient's enrollee ID on his or her member ID card. If you search based on the Patient ID and receive a response indicating the patient's plan is inactive, submit another inquiry that doesn't include the patient's enrollee ID. The patient may have changed plans and received a new enrollee ID number.
  - After taking the above action, if the patient's coverage is still displaying as inactive on the current date, change the "As of Date" to a date when coverage was active. Inactive coverage will display an end date. You can select a date prior to the end date for more information on the prior coverage. Information is available on coverage up to one year prior to the current date.
- **Narrow the benefit results** — Before clicking on the patient box and selecting *Submit*, click on the *Benefit/Service Type* drop-down menu. You can select multiple benefits in this field to narrow down the benefits you want to view. Click on *Search,* and then click on the *Coverage and Benefits* tab to see details for the benefits you've selected.
- **Find the result you need** — A categorized list of frequently viewed benefits information is on the left side of the screen. You can click the links listed under each benefit or service type to navigate to the corresponding section of the *Coverage and Benefits* screen.
- **Some health plans have a custom message** — If a patient's plan has a custom message, you'll find it under the Blue Cross and BCN logo in the green bar.
- **Networks** — On the *Coverage and Benefits* tab, you may see some filters by network such as "All Networks," "In Network" or "Out of Network." These links provide the benefits but don't indicate the network status of the health care provider. To determine the network status for a specific provider, look up the provider in our online provider search at **bcbsm.com/find-a-doctor**. For detailed steps, review **Finding your plans and networks**.
- **Coordination of benefits** — Coordination of benefits information is available on the *Patient Information* tab in the *Payer Details* section under *Other or Additional Payers*.
- **Medicare and Medicaid contracts** — Medicare and Medicaid are listed as separate payers. For more information, see pages 12 and 13 of **Transitioning to the Availity provider portal frequently asked questions for providers**.
- **Non-Michigan Blue plan members** — To check eligibility and benefits for an out-of-state Blue plan member, go to the *Patient Information* section, and select *Click here to search for Federal Employee Program or Blue Exchange members*.
- **Get training** — For more details on how to use eligibility and benefits, go to **Get Up to Speed with Training**, and select *Availity Overview, Payer Spaces, Eligibility & Benefits*.

Direct your questions to Availity Client Services at 1-800-AVAILITY (282-4548), from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding holidays). Request an ACS ticket number for reference in case this call doesn't resolve your problem and follow-up assistance is needed.

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

Have you been surprised by a paper check when you expected electronic payment?

If you submit a claim with a tax ID that doesn't match what we have in our system for electronic funds transfer, or EFT, the claim will pay by paper check instead of EFT. Review your recent vouchers that were paid via EFT to note the tax ID.

If you need to revise your EFT information, check out EFT training within the Availity Learning Center or in the **Get Up to Speed with Training** website, or call 1-800-AVAILITY (282-4548), from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding holidays). Request an ACS ticket number for reference in case this call doesn't resolve your problem and you need follow-up assistance.

Follow these tips for checking claim status and viewing remittance advices and vouchers in Availity

If you're still getting accustomed to using our new provider portal, Availity® Essentials, here are some tips that can help with claims-related activities.

Checking claim status

Click on *Claims & Payments* and then click on *Claim Status*. If you have more than one organization, select the appropriate one, then select BCBS MICHIGAN AND BLUE CARE NETWORK as the payer. Then, follow these four steps:

1. Use *Member Search* to select the patient.
2. Once you find the patient, click the patient's row. This opens the *HIPAA Standard* tab.
3. Select the billing provider and complete the fields in the Claim Information section.
4. Click *Submit*.

Tip: Allow at least 72 hours for the claim to be processed before checking its status.

Tip: For Federal Employee Program contracts or contracts from non-Michigan Blue plans, start with the HIPAA Standard tab.

Using the Remittance Viewer in Availity

Click on *Claims & Payments* and then click on *Remittance Viewer* twice.

Tip: When you open the Remittance Viewer, you'll see a popup screen titled *Welcome to Remittance Viewer* with a link at the bottom to a demo on using the tool.

The Remittance Viewer screen has two tabs:

- *Check/EFT* – This tab opens by default. Use this to search with payment information.
- *Claim* – Use this tab to search with claim information.

Tip: Make sure the date span is correct for the search option you use. In the *Check/EFT* tab, it's best to search for a couple days before and after the check date.

Tip: When you find results, you'll see a row of data. On the right, there will be an *Actions* column. One of the items is labeled *EOP/EOB* when you hover your mouse over it. This is the voucher you're used to seeing in Provider Secured Services/web-DENIS. Another of the items is labeled *Download* when you hover your mouse over it. This is the electronic remittance advice which you can download as a PDF.

Submitting claims through the Availity Claim Submission tool

If you use Availity's Claims Submission tool to submit claims to Blue Cross and BCN, you need to make sure the member prefix is included with the member contract number on your claim. The prefix is usually three alpha characters preceding the 9-digit contract number. Federal

Please see Follow these tips continued on Page 5

Network Operations

Employee Program contract numbers are an exception, with an R followed by an 8-digit contract number.

In some cases, when you search for a Blue Cross or BCN member within Availity, the results do not display the contract prefix. If you submit a claim that doesn't include the prefix, the claim will reject due to an incomplete or invalid contract number.

To find the prefix, look up the patient in Availity's Eligibility and Benefits Inquiry tool (found under the Patient Registration dropdown) and click on the "View Member ID Card" link near the top of the results page. The ID card image will include the complete contract number (called the Subscriber ID), including the prefix.

Training assistance

Here's where you can learn more.

- Go to **Get Up to Speed with Training**, and select either a live or recorded webinar for Blue Cross and BCN-specific training.
- Go to the Availity Learning Center. Here's how:
  1. Within Availity, click on *Help & Training*.
  2. Click on *Get Trained*.
  3. In the search bar, click the Catalog icon (which looks like a folder) and search for either:
     - Claim Status – Training Demo
     - Availity Claim Status
     - Remittance Solutions – Training Demo
     - Remittance Viewer: Tips for finding what you need. Fast.

Troubleshooting

If you're having problems checking claim status or using the Remittance Viewer, ask your Availity administrator to make sure you have the claim status role assigned to you.

Contact Availity Client Services for one-on-one assistance. Call 1-800-AVAILITY (282-4548), from 8 a.m. to 8 p.m. Eastern time, Monday through Friday (excluding holidays). Request an ACS ticket number for reference in case this call doesn't resolve your problem and follow-up assistance is needed.

Still need to register?

Find out how at **Register for Availity Essentials**. Learn more at **Get Started with Availity Essentials**.

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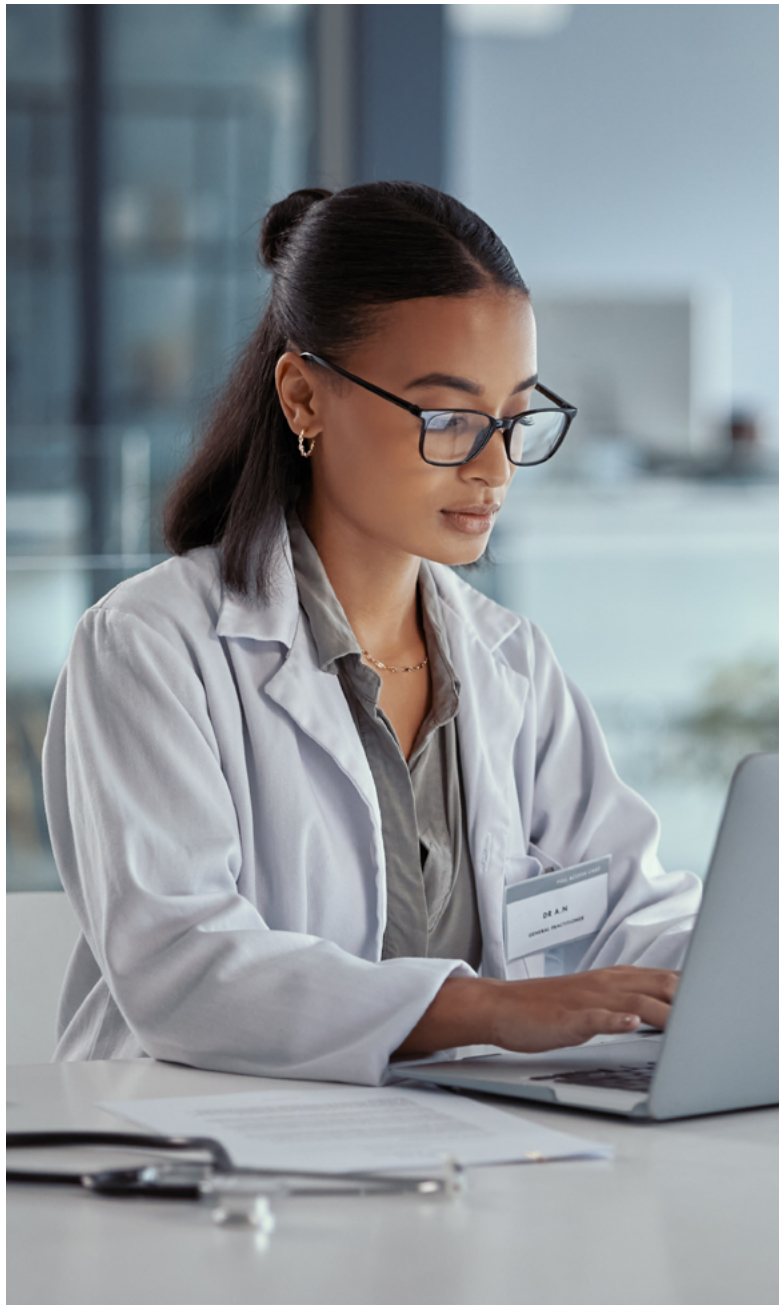


Learn more about our new virtual primary care plan

As previously announced in the **November-December 2022 issue of *BCN Provider News***, 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.

You can learn more about this plan in our *Virtual Primary Care Frequently Asked Questions* document. Here's how to find it within our provider portal:

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

1. Click *Payer Spaces* on the Availity menu bar.
2. Click the BCBSM and BCN logo.
3. Click *Secure Provider Resources (Blue Cross and BCN)* on the Resources tab.
4. Choose *BCN* from the *Products* drop-down menu.

Important referral notes about the plan

- In the event a member needs an in-person evaluation for a non-urgent low acuity need, the Doctor On Demand virtual primary care physician may ask for in-network BCN providers' support. Doctor On Demand will submit a referral via e-referral to the participating BCN PCP. Just like all other referrals, BCN providers can find a Doctor On Demand referred case to them in the list of open cases on the e-referral dashboard home page. You can read more about the e-referral dashboard in the *Navigating the Dashboard* section of the ***e-referral User Guide*** or the ***Navigating the Dashboard Home Page*** online self-paced e-learning module found on **ereferrals.bcbsm.com**.
- Referrals are required for adult members (age 18 and older) if in-person care is needed (except for urgent care, emergency room, behavioral health and routine women's health services). This also applies to adult members who reside in our West, Mid and Upper Peninsula regions. Pediatric referrals follow the standard BCN processes.
- Starting in January, BCN providers that need to contact the member's virtual PCP should call Doctor On Demand by Included Health at 1-855-431-5552. Please have the member's information available to connect to that member's virtual PCP or care team. This information can be found when checking the member's eligibility and benefits in our provider portal (**availity.com**).

Precision medicine and pharmacogenomics educational webinar recordings now available

On Jan.1, 2023, Blue Care Network is launching an end-to-end precision medicine pharmacogenomics, or PGx, program called Blue Cross Personalized Medicine℠.

To prepare providers, BCN hosted pharmacogenomics educational sessions as announced in the **November-December 2022 issue of *BCN Provider News***. These sessions focused on:

- Specific case studies as they pertain to various disease states and specialties.
- The patients' experience from invitation through testing completion and medication treatment options tailored to their individual needs.

We canceled the cardiology webinar that was originally scheduled for Dec. 8, 2022. It will be rescheduled in early 2023. We apologize for any inconvenience caused by the cancellation.

Session date	Case study focus	CME credit
November 10	Primary Care	Yes
November 15	Behavioral Health	No

To watch the recorded sessions, visit the provider training website. Use the words PCP, PGx, or personalized to search for the sessions.

Please see Precision medicine continued on Page 7

Network Operations

Access to the provider training website

- Click **here** if you are already registered for the provider training website.
- Click **here** to request access to the provider training website.

  Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan and Blue Care Network for other provider-related needs. This will become your login ID.

Statement of Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Michigan State Medical Society and Blue Care Network of Michigan. The Michigan State Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

AMA Credit Designation Statement

The Michigan State Medical Society designates this live activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

HEDIS® medical record reviews begin in February

Each year from February through May, Blue Cross Blue Shield of Michigan conducts Healthcare Effectiveness Data and Information Set (HEDIS®) medical record reviews for members who live in Michigan. This year, Blue Cross HEDIS clinical consultants will conduct HEDIS reviews for members with Blue Cross PPO and BCN HMO plans (including commercial, Medicare Plus Blue℠ and individual products) who had services in 2022.

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 plan. Blue Cross Blue Shield of Michigan is authorized to retrieve medical records for patients who live in Michigan and are enrolled in any Blue Medicare Advantage PPO plan, including those outside of Michigan.

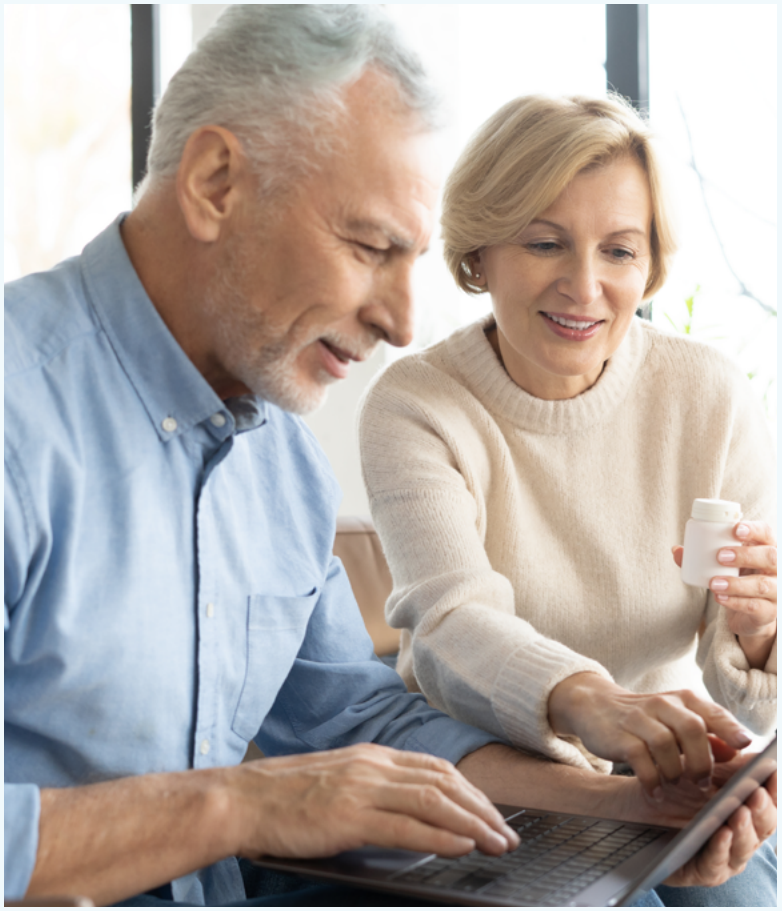
Inovalon, an independent data and analytics firm, is authorized to retrieve medical records for patients enrolled in all Blue Cross PPO and HMO plans as well as Blue Medicare Advantage PFFS and HMO plans.

For the HEDIS reviews, we look 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.

Our 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 ekraft@bcbsm.com.

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



Learn more about patient experience resources

The Centers for Medicare & Medicaid Services continues to emphasize the importance of the patient experience in all their programs. Blue Cross Blue Shield of Michigan and Blue Care Network administer the Clinician and Group Consumer Assessment of Healthcare Providers and Systems®, or CG-CAHPS, a nationally recognized survey that's widely used to collect data about patient experiences and monitor provider performance.

We've added a page on our *Provider Resources* site to provide more details about the CG-CAHPS survey and our patient experience resources, including our Provider Experience podcast series. (To read more, see *Podcasts give you quick, easy tools for improving the patient experience* on **Page 16** of this issue)

You can find the *Provider Experience* page on the *Member Care* tab. To get there:

- Log in to our provider portal at **availity.com**.
- Click on *Payer Spaces* on the Availity menu bar.
- Click on the BCBSM and BCN logo.
- Click on *Secure Provider Resources (Blue Cross and BCN)* on the *Resources* tab.
- Click on *Patient Experience* on the *Member Care* tab.

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

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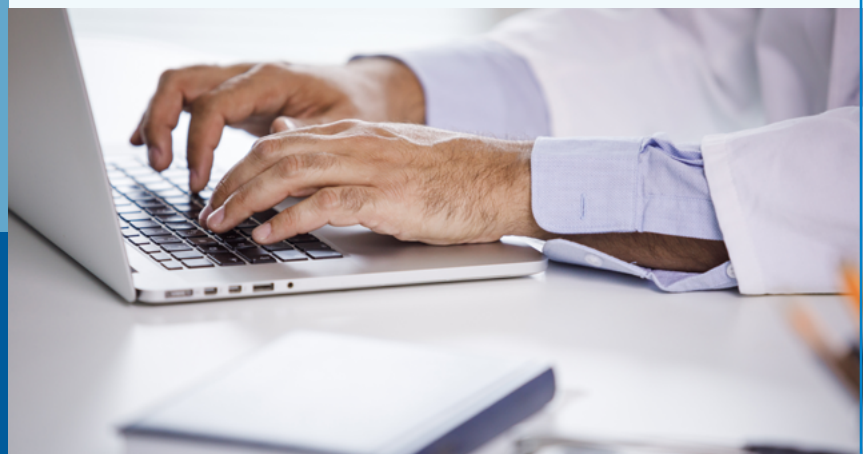


New! Healthy Blue Choices℠ POS now available to FCA employees

Healthy Blue Choices℠ POS is a new point-of-service product for FCA non-bargaining employees and retirees* that allows the flexibility to receive covered health care services in or out of network without a referral. It is administered by Blue Care Network and works similarly to our popular Blue Elect Plus℠ POS plan. **Healthy Blue Choices members don't need a referral for any covered service.** They can refer themselves to any provider — even to providers who are considered out of network for this product.

Requirements for selecting a primary care provider

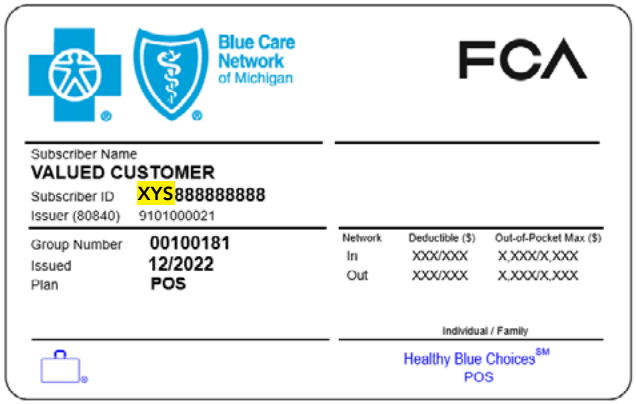
Healthy Blue Choices POS members with a Michigan address must select a BCN primary care physician; however, they also have the option to receive covered health care services in or out of network without a referral. Members who live outside of Michigan, with a non-Michigan address, don't need an assigned primary care physician. They also don't need a referral — they just need to see a BlueCard-participating provider if they want to pay the lower in-network out-of-pocket costs.

Important information to know

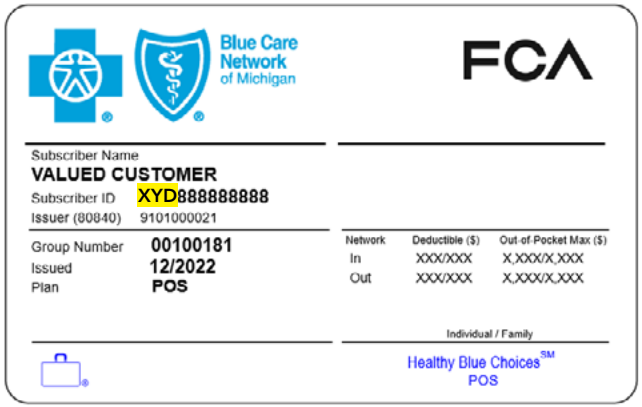
- All members have lower costs when seeing in-network providers (those who are contracted with BCN or a BlueCard-participating provider).
- Authorization requirements apply for certain services provided by both in- and out-of-network providers.
- Some services are covered from in-network providers only, including most preventive services defined by the Affordable Care Act, office visits, durable medical equipment, prosthetics and orthotics, diabetic supplies, routine prenatal care (for members with active employee coverage) and colonoscopy (for members with retiree coverage).
- Some services aren't handled through Blue Care Network, including behavioral health services, infertility treatment services and pharmacy.

Please see New! Healthy Blue continued on Page 9

Healthy Blue Choices POS for employees



Healthy Blue Choices for retirees



More information is available

Refer to the **Healthy Blue Choices℠ POS webpage** for more information. For questions about Healthy Blue Choices POS, call Provider Inquiry:

- Physicians/Professionals: 1-800-344-8525
- Hospitals/Facilities: 1-800-249-5103

* FCA bargaining employees are covered under a separate health plan administered by Blue Care Network.

Ordering transfers from noncontracted (or nonparticipating) ambulance services costs members money

Providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers. This applies to transfers for Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members.

For more information, see the article on **Page 14**.

Podcasts give you quick, easy tools for improving the patient experience

As part of our ongoing efforts to help practices improve the patient experience, we've developed a podcast series called "Practice Up." The four podcasts included in the series are short and engaging, allowing physicians and other health care providers to listen at their convenience.

For more information, see the article on **Page 16**.

Find out more about the new Blue Cross® Local HMO and BCN Advantage℠ Local HMO

Blue Cross Local HMO and BCN Advantage Local HMO are new products that are part of a new 2023 Local 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 primarily with Ascension and Trinity Health.

For more information, see the article on **Page 10**.

Find out more about the new Blue Cross® Local HMO and BCN Advantage℠ Local HMO

As previously announced in the **November-December 2022 issue of *BCN Provider News*** on pages 3 and 8, Blue Cross Local HMO and BCN Advantage Local HMO are new products that are part of a new 2023 Local 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 primarily 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, BCN authorization is required for the member to receive care. BCN will only authorize the service if it is something that can't be performed within the network. Standard BCN clinical review requirements apply.

Referrals are handled like other similar BCN health plans.

- Blue Cross Local HMO, a BCN commercial health plan in the Southeast region, requires primary care physicians to submit referrals through the e-referral system.
- BCN Advantage Local HMO, a BCN Advantage health plan, does not require referrals to be submitted through the e-referral system, but still expects the primary care physician to coordinate care.

To see a list of participating hospitals and medical care groups, check your network status or see images of the member ID cards, please see the ***Blue Cross Local HMO and BCN AdvantageSM Local HMO flyer (PDF)***. You can also find this flyer on 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 *BCN* or *BCN Advantage* from the *Products* drop-down menu.

Prior authorization and billing reminders for SNF interrupted stays for Medicare Advantage members

Per Centers for Medicare & Medicaid Services guidance, a skilled nursing facility interrupted stay occurs when a patient is discharged from a SNF and is readmitted to the same SNF within three consecutive days. When this occurs:

- The readmission or subsequent stay is considered a continuation of the previous stay.
- One claim must be submitted for both stays.
- The completion of new patient assessments is optional.
- The variable per diem isn't reset.

For more information, see the "Interrupted Stay Policy" section of the Medicare Learning Network® document titled **SNF PPS: Patient Driven Payment Model**.

How naviHealth issues authorizations for SNF interrupted stays

naviHealth's authorization process is based on their medical necessity review process.

If a patient who is receiving skilled services leaves a SNF for the emergency department, for an observation stay or for an acute-care hospital inpatient stay and:

Please see Prior authorization and billing continued on Page 11

- Returns to the same SNF **before two midnights have passed**, naviHealth will use the original prior authorization number.
- Returns to the same SNF **after two or more midnights have passed**, naviHealth will create a new authorization number.

How to submit claims for SNF interrupted stays

Here's what you need to know about billing for SNF interrupted stays:

- You must submit only one claim for both stays.
- Submitting authorization numbers on Medicare Plus Blue and BCN Advantage claims for post-acute care stays is **optional**. If you choose to include an authorization number on the claim, include the prior authorization number for the initial SNF stay.
- If naviHealth assigns a different patient-driven payment model, or PDPM, code for the subsequent stay:
  1. Include a claim line for the original dates of service and PDPM code.
  2. Include a separate or new claim line for the subsequent dates of service and the second PDPM code.

Reminders:

- naviHealth authorizes the first four digits of the PDPM code based on the associated case mix groups, or CMGs. The provider is responsible for assigning the appropriate fifth digit.
- Providers are responsible for billing appropriately.
- Claims for unauthorized services and procedures are subject to denial.

Resources for CMS billing guidance

- **Medicare Claims Processing Manual Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing** — Section 120.2 - Interrupted Stay Policy
- **Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance** — Section 30.1 - Administrative Level of Care Presumption

Additional information

For more information, see the document titled **Post-acute care services: Frequently asked questions for providers**. We updated this document to include the information in this alert.

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.

Blue Cross and BCN receive high Medicare Star Ratings from CMS again this year

The Centers for Medicare & Medicaid Services recently announced its 2023 Medicare Star Ratings — and Blue Cross Blue Shield of Michigan achieved strong results.

Both our BCN Advantage℠ HMO plan and our Medicare Plus Blue℠ PPO plan captured 4.5-Star ratings, making our plans once again among the highest-rated in the country.

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 to help consumers select a Medicare Advantage plan that works best for them.

"These phenomenal ratings reflect our dedication to provide our Medicare members with service that goes above and beyond," said Daniel J. Loepp, Blue Cross president and CEO. "We are grateful to the care teams in our network who work closely with our members to meet their health care needs."

Medicare considers five categories when assigning Star Ratings:

- 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

Please see Blue Cross and BCN continued on Page 12

BCN Advantage

- How many members leave the plan each year

Blue Cross Blue Shield of Michigan's high ratings for 2023 reflect sustained performance 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

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 our physician partners and the efforts of each patient care team. These professionals interact with our patients every day and are helping to provide quality care to everyone they touch," he said.

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 for our members.

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

CAHPS®, which stands for Consumer Assessment of Healthcare Providers and Systems, is a registered trademark of the Agency for Healthcare Quality and Research.

How Landmark can support primary care providers as they care for our most vulnerable Medicare Advantage members

On Jan. 1, 2023, all Medicare Plus Blue and BCN Advantage members who have multiple chronic conditions and reside in Michigan's Lower Peninsula will be eligible for Blue Cross Blue Shield of Michigan and Blue Care Network's high-intensity in-home care program. This program uses the services of Landmark Health L.L.C., an independent company that provides Blue Cross and BCN with in-home care services.

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

Xenpozyme™ and Zynteglo® to require prior authorization for Medicare Advantage members, starting Nov. 1

For dates of service on or after Nov. 1, 2022, we're adding a prior authorization requirement for Medicare Plus Blue and BCN Advantage members for the following medications:

- Xenpozyme™ (olipudase alfa-rpcp), HCPCS code J3590
- Zynteglo® (betibeglogene autotemcel), HCPCS code J3590

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

Pemfexy® to require prior authorization for most members, starting Feb. 9

For dates of service on or after Feb. 9, 2023, Pemfexy (pemetrexed), HCPCS code J9304, will require prior authorization through AIM Specialty Health®. This drug is part of members' medical benefits, not their pharmacy benefits.

See the article on **Page 26** for details.

BCN Advantage

How BCN Advantage will reimburse carrier-priced codes, starting Jan. 1

Starting Jan. 1, 2023, BCN Advantage will follow Centers for Medicare & Medicaid Services guidelines when establishing reimbursement for procedure codes that CMS lists as carrier priced. This will apply to services for BCN Advantage members.

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

Medicare Plus Blue and BCN Advantage claims audits will transition from HMS to Cotiviti

Effective Dec. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will transition their audit services for Medicare Plus Blue and BCN Advantage claim reviews from HMS to Cotiviti, an independent company that provides auditing support services for Blue Cross and BCN. Cotiviti contracted with HMS in the past for clinical chart review services and has now purchased the company.

See the article on **Page 29** for details.

Ordering transfers from noncontracted (or nonparticipating) ambulance services costs members money

Providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers. This applies to transfers for Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members.

Noncontracted ambulance services may balance bill members, which may result in members being charged large amounts for these services.

You can avoid this situation by using only contracted (or participating) ground ambulance services for non-emergency transfers. To determine which ground ambulance services are contracted with or participate with a member's health plan:

1. Go to **bcbsm.com**.
2. Click ***Find a Doctor***.
3. Click the *Search without logging in* link.
4. If prompted, choose a location.
5. In the upper-right corner of the screen, do one of the following:
   - Click the *I don't know my network* button.
   - Click the *Change your location or plan* link and then click *I don't know my network*.
6. Click the *Find a different plan* button.
7. Select the appropriate plan.
8. Click the *Confirm selection* button.
9. Click *Places by type*.
10. Enter *Land ambulance* or the name of a specific ambulance provider, and press Enter.

The search results include the ground ambulance services that are contracted with or participate with the plan you selected.

See our *Ground Ambulance Services* medical policy for additional information. To view the policy:

1. Go to **bcbsm.com/providers**.
2. Click *Resources*.
3. Scroll down the page and click the *Search Medical Policies* button.
4. In the **Medical Policy Router Search** page, enter **ground ambulance services** in the Policy/Topic Keyword field and press Enter.
5. Click the *Medical Policy – Ground Ambulance Services* link.

Reminder: DME/P&O and telehealth visits

Blue Cross and Blue Care Network follow the Centers for Medicare & Medicaid Services COVID-19 PHE Interim Final Rules for DME/P&O items that allow exceptions to requirements for face-to-face encounters to avoid exposure of vulnerable populations. Telehealth visits can be used to prescribe DME/P&O items and medical supplies, effective March 18, 2020, until the end of the public health emergency, as indicated in our **Temporary changes due to the COVID-19 pandemic** document. For more information, see the **CMS Medicare Learning Network guidance**.

We'll communicate updated telehealth requirements for DME/P&O and medical supplies after the PHE has ended.

How Landmark can support primary care providers as they care for our most vulnerable Medicare Advantage members

On Jan. 1, 2023, all Medicare Plus Blue and BCN Advantage members who have multiple chronic conditions and reside in Michigan's Lower Peninsula will be eligible for Blue Cross Blue Shield of Michigan and Blue Care Network's high-intensity in-home care program. This program uses the services of Landmark Health L.L.C., an independent company that provides Blue Cross and BCN with in-home care services.

The Landmark program

Using a physician-led, interdisciplinary team, the Landmark program complements office-based primary care by:

- Collaborating and coordinating with each member's primary care provider, using the primary care provider's preferred method of communication
- Supporting frail, elderly patients who want to manage their conditions through in-home care
- Meeting patients in the comfort of their homes
- Delivering geriatric care, including medical, behavioral, urgent care, medication management and 24/7 nurse triage

The program doesn't replace members' primary care providers or other health care providers. Instead, the Landmark team provides supplemental support between members' regularly scheduled medical appointments, when it's often needed most.

The Landmark program is a member benefit. Members who are eligible for the Landmark program decide whether they want to participate in the program.

Learning opportunities

Blue Cross, BCN and Landmark are available to meet with primary care practices, providers and care managers to answer questions about Landmark's care model and coordination of care.

Discussion topics include:

- Coordination of care between Landmark and an identified person in the practice
- The best method of communication with the practice and how to coordinate on urgent patient needs
- How and when practices can call on Landmark for eligible or engaged patients when the patient has an urgent need or cannot come into the office
- Feedback on Landmark communication with primary care providers

If you want to participate in an open-forum discussion, email the Care Delivery Solutions team at CareDeliverySolutionsProgramMtg@bcbsm.com.

How patients are identified for the Landmark program

Blue Cross and BCN identify eligible members through specific criteria related to level and number of qualifying chronic conditions, age, geographic location and other factors (for example, frailty).

You can refer patients to the Landmark program. To do this, send an encrypted email message to CareDeliverySolutionsProgramMtg@bcbsm.com with the patient's:

- First and last name
- Contract ID
- Date of birth
- Any pertinent medical information, including chronic conditions.

For the patients you refer, we'll review the information you provide and reply to your email to let you know whether the patient will be accepted into the Landmark program.

Additional information

To learn more about our program with Landmark, see the **High-intensity in-home care program: Frequently asked questions for providers** document.

* Providers who are in full-risk arrangements have separate provisions for this benefit.

BCN and BCN Advantage℠ providers can begin billing PDCM services, effective Jan. 1

Effective Jan. 1, 2023, BCN commercial and BCN Advantage℠ Patient-Centered Medical Home designated providers may begin billing Blue Care Network for Provider-Delivered Care Management services. These payments do not have a corresponding reduction in capitation and are equal to the PPO base fee schedule.

Provider-Delivered Care Management builds upon PCMH in transforming care delivery, enabling providers to deliver coordinated team-based care. The program allows physician-led health care teams to deliver services that are billed by qualified practitioners. By partnering with health care providers to deliver care management in the doctor's office, Blue Care Network helps to ensure that patients with chronic conditions receive more effective, personalized care that leads to better clinical outcomes and lower costs for patients.

Additional benefits of PDCM services include:

- Decreased unnecessary emergency department utilization and inpatient admissions
- Increased closure of quality gaps in care – a HEDIS® measure for BCN Advantage
- Better patient experience through care coordination by the support of a larger care team
- Improved chronic disease management and outcomes (hypertension, diabetes, etc.)

This initiative aligns BCN commercial and BCN Advantage providers with Blue Cross commercial and Medicare Plus Blue℠ providers in the PDCM program.

Some self-funded employer groups may elect to not participate with the PDCM program. FCA's new Healthy Blue Choices℠ POS health plan is not participating in the PDCM program. For more information on Healthy Blue Choices POS, see the article on **Page 8**.

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

Podcasts give you quick, easy tools for improving the patient experience

As part of our ongoing efforts to help practices improve the patient experience, we've developed a podcast series called "Practice Up." The four podcasts included in the series are short and engaging, allowing physicians and other health care providers to listen at their convenience.

Podcasts include the following:

- Episode 1: A Minute to Win It
- Episode 2: What Matters Most
- Episode 3: Finding Room for Feelings
- Episode 4: Rock the Wrap-up

"These podcasts give providers concrete tools they can implement that will improve the patient experience," said Martha Walsh, M.D., senior medical director and associate chief medical officer for Provider Engagement. "Many of us think of the patient experience as very subjective, but the reality is there are very objective things that a provider can implement in their interactions with patients that will improve the patient experience. Our goal in creating these podcasts was not only to improve the patient experience, but also to help providers improve their own experience."

CME credit

Listening to all four of the episodes — and scoring 100% on the quiz questions — will also allow you to apply for continuing medical education credit. To receive credit, you must access the podcasts through the provider training site.

Accessing the podcasts

To access the podcasts, follow these steps:

Please see Podcasts continued on Page 17

1. Open the **registration page**.
2. Complete the registration, which takes less than a minute. (We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan for provider-related needs. This will become your login ID.)
3. Follow the **link** to log in.
4. Scroll down and click on the link that says *Click here to locate the podcasts*.

Note: If you already have access to the site, you can go directly to Step 3 to log in. Currently, nearly 1,200 providers have access to our provider training site.

For more information

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

Reminder: Blue Cross to launch new family building and maternity support solution

To read more about maternal health

1. See the **article on eliminating maternal health disparities** that ran in the September-October issue of this Hospital and Physician Update.
2. See the articles about maternal health that ran in the **November-December 2021** and **May-June 2022** issues of Hospital and Physician Update.
3. Learn about the **Blue Distinction® Specialty** Care programs, including the Blue Distinction Centers for Maternity Care program.

As you may have read in the October *Record*, Blue Cross Blue Shield of Michigan and Blue Care Network are launching a new family building and maternity **support solution**. It's part of our ongoing commitment to improving maternal health and eliminating care disparities.

We're working with Maven Clinic, an independent company, to provide a program that supports all backgrounds, lifestyles and phases of starting or growing a family. These services are expected to improve clinical outcomes for parents and babies.

Our Family Building and Maternity Support Solution combines Maven's comprehensive, personalized digital care navigation with our wide-ranging network and benefits to give members high-quality, clinically appropriate and convenient care, including benefit guidance using data-driven insights.

The new support solution includes three programs through the Maven app, which are available to our self-funded groups to purchase and implement, starting Jan. 1, 2023:

- **Family Building program** — Provides support and information for different paths to parenthood, such as fertility treatments, intrauterine insemination, in vitro fertilization and egg freezing, as well as surrogacy and adoption. 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 pregnancy and for three months postpartum. The program includes support for prenatal and postpartum care, high-risk pregnancy and care within a neonatal intensive care unit. In addition to self-funded groups, this program will also be available to members who have Blue Cross and BCN commercial fully insured group plans, as well as those who have individual coverage.
- **Parenting & Pediatrics program** — Supports parents as they raise their children from ages 1 to 10. The program includes support for pediatric care, parent coaching, special needs and child care navigation.

Please see maternity support solution continued on Page 18

Each of the programs includes access to:

- **A dedicated care advocate** who is matched to the member and will provide 24/7, personalized, one-on-one care and benefits navigation, answer questions about the member's pregnancy and postpartum journey, recommend virtual coaches for specific needs and refer members to high-quality, in-network health care providers.
- **Video appointments with top-rated coaches** from more than 30 clinical specialties**,** providing personalized and culturally competent care which is available 24/7. Coaches include OB-GYNs, mental health specialists, lactation consultants, nutritionists and sleep coaches. Coaching is available in more than 35 languages.
- **Personalized resources**, including articles and other content related to prenatal health, postpartum depression and how to return to work with more confidence. Resources also include classes led by coaches and community forums so members can connect with others on similar journeys.

Fertility and maternity benefits

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

Members who don't have access to this support solution can visit **bcbsm.com/familybuilding** for guidance on starting or growing a family. We'll provide additional information about how we're providing family building and maternal suvpport programs in future issues of our provider newsletters.

New microsite gives members access to maternity, family-building resources

Blue Cross Blue Shield of Michigan has developed a **microsite** that enhances the experience of Blue Cross and Blue Care Network members seeking to build families, and improves clinical outcomes for mothers and babies.

It's part of a comprehensive maternal health strategy to improve member education about maternal health coverage and how to navigate maternity benefits. This strategy can help encourage members to get recommended care and increase their engagement in available Blue Cross programs.

Members on a journey to parenthood can find information on this new **family building and maternity microsite** at **bcbsm.com**. The site includes information for each stage of a family building journey, from fertility testing, counseling and treatments to prepregnancy, pregnancy and labor and delivery, including pregnancy loss, postpartum and pediatrics.

Each page on the microsite also includes a link to our behavioral health site where members can find information about mental health support throughout their family-building journey. Another link directs them to their Blue Cross member account where they can get information about their health plan coverage.

Additional webpage topics include:

Prepregnancy planning

- Fertility testing, counseling and treatments
- Egg freezing

Pregnancy, labor and delivery

- Prenatal vitamins
- Prenatal exam schedule
- Prenatal testing
- Pregnancy loss
- Self-care
- Birthing experience, traditional and nontraditional
- Midwives, doulas and birthing classes
- Preparing for baby's arrival
- Breast pump coverage
- Hospital checklist
- Family medical leave
- Labor and delivery, epidural and cesarean section

Postpartum care pediatrics

- Lactation and breastfeeding
- Insurance for your newborn
- Baby's first physical
- Postpartum physical
- Pregnancy prevention and pills, injection and IUDs, morning-after pill, condom and vasectomies, having your tubes tied, insurance coverage

You can direct Blue Cross members who are on a family planning journey to our **family building and maternity microsite**.

Services rendered as result of telemarketing subject to post-service audit

Blue Cross Blue Shield of Michigan and Blue Care Network work with health care providers to facilitate the provision of optimal medical care for our members. To this end, we reserve the right to audit services provided to our members to ensure these services were medically necessary.

Blue Cross and BCN don't condone telemarketing services, defined as provider solicitation or cold calling of our members, to prescribe items that may be medically unnecessary, including, but not limited to, durable medical equipment, genetic testing, wound care items or prescription medication. All services are subject to a post-service audit and possible payment recovery if it's determined that the services were rendered as a result of providers soliciting members.

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:

What InterQual subsets for inpatient level of care can be used to review for patients who expire?

Answer:

If a member is critically sick and receiving aggressive interventions, often the case will meet InterQual at an Acute level of care or higher.

The following is a non-inclusive list of ways that members near end of life commonly meet criteria at an inpatient level of care:

- Continuous vasopressors – Most subsets contain a Critical level criterion that can be selected to approve an inpatient level of care if there is clinical support that a member required continuous vasopressors.
- Invasive monitoring – Many subsets contain a Critical level criterion that can be selected to approve an inpatient level of care if there is clinical support that a member required invasive monitoring such as an arterial line or "A-line," central venous pressure monitoring, or even a Swan Ganz catheter.
- Mechanical Ventilation – Many subsets contain a Critical level criterion that can "give the case credit" for when the member requires mechanical ventilation due to critical illness.
- The General Trauma subset contains a criterion that can be utilized when a critically ill patient has a cardiac arrest, is successfully resuscitated, and requires post resuscitation care ("Cardiac arrest and post resuscitation care ≤ 2 days").
- There is a criterion in the General Medical-Neurological subset for patients whose plans of care are focused on comfort rather than aggressive prolongation of life. It's essentially an "admit for placement" criterion but also requires the member be unconscious. This allows the facility time to arrange for an admission to a lower level of care such as home hospice. The criterion is "Unconscious and DNR, DNI, or CMO and discharge planning." There is an informational note attached to this criterion which may be helpful.

Please note that some expiration cases may not meet an inpatient level of care and may be appropriate for a lower level of care such as Observation. There is no specific, designated location within IQ to process expiration cases or even cardiac arrests when the patient does not survive.

Also, it may be helpful to note that BCN's current practice is to focus our InterQual review on the day of inpatient admission (for Non Condition Specific Local Rule cases). On the other hand, for diagnoses associated with the Condition Specific Local Rules, BCN's current practice is to focus our InterQual review on the third Episode Day of care.

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

- Endothelial Keratoplasty
- Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment and Immunotherapy in Metastatic Colorectal Cancer (KRAS, NRAS, BRAF, MMR/MSI, HER2, and TMB)
- Aqueous Shunts and Stents for Glaucoma
- Small Bowel/Liver and Multivisceral Transplant
- Temporomandibular Joint Disorder
- BMT - Hematopoietic Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome
- Amniotic Membrane and Amniotic Fluid
- Identification of Microorganisms Using Nucleic Acid Probes
- Remote Therapeutic Monitoring
- Medical Formula for Inborn Errors of Metabolism
- Contraception and Voluntary Sterilization

Noncovered services

- Radiofrequency Ablation of Basivertebral Nerve for Low Back Pain
- Cryoablation or Cryoneurolysis (e.g., iovera° System) of Peripheral Nerves

New radiology-focused initiative aims to improve quality of care and patient outcomes

Blue Cross Blue Shield of Michigan and Blue Care Network are engaging Covera Health to launch a radiology-focused quality improvement program to help us better support radiologists and referring providers in their efforts to improve diagnostic quality, overall care and patient outcomes.

Covera's quality improvement programs support radiology facilities and radiologists in their efforts to:

- Engage in continuous quality improvement.
- Identify peer learning opportunities.
- Improve quality of care provided to members.
- Improve patient outcomes.

Participating practices and radiologists will:

- Have access to Covera's Diagnostic Intelligence Platform, which includes quality assurance tools that incorporate clinically validated artificial intelligence and data science.
- Have access to confidential quality assurance analytics and quality insights, including study-level, provider-level and practice-level reporting. This includes actionable insights to target clinical areas where additional peer learning and educational activities may be beneficial.
- Be eligible for a high-quality designation. This designation makes it easier for referring providers to refer patients to high-quality radiology centers, which will help to improve member outcomes.

Program participation and quality assurance insights

- Participation in this program will be voluntary and will be available to all radiology providers and facilities. Neither reimbursement nor value-based arrangements will be affected if a practice or radiologist chooses not to participate in Covera's quality improvement program.
- To participate in the program, practices must apply and complete participation agreements with Covera.
- As part of its certification by the Agency for Healthcare Research and Quality as a patient safety organization, Covera cannot share sensitive provider data with other parties, including Blue Cross and BCN. This includes data related to quality assurance analytics and insights.

Program availability

Starting in April 2023, the program will be available for the following groups and members:

- BCN commercial — Members who have coverage through fully insured groups and members who have individual coverage
- BCN Advantage℠ — All groups and all members who have individual coverage
- Blue Cross commercial — Members who have coverage through fully insured groups and members who have individual coverage
- Medicare Plus Blue℠ — All groups and all members who have individual coverage

Please see New radiology-focused initiative continued on Page 23

Patient Care/ Quality

Designations for quality and value

On prior authorization requests approved by AIM Specialty Health®, Covera designations will display as follows:

- For BCN commercial, BCN Advantage and Medicare Plus Blue members, facilities will be identified as having high-quality designations and will be listed **as recommended providers**.
- For Blue Cross commercial, facilities will be identified as having high-quality designations.

Providers that are designated as high quality and are also cost effective will receive an additional "high-value" designation on prior authorization requests approved by AIM. Cost efficiency is determined through cost factors including (but not limited to):

- The cost of the diagnostic service being requested
- The average cost of the service in the geographic area

Only radiology centers that have been designated as high-quality are eligible to receive the high-value designation.

Register for webinars to learn more

Blue Cross, BCN and Covera Health will host webinars throughout the program, starting in January 2023. The webinars will provide an overview of the Covera programs, how they improved outcomes for members and providers and how they can enhance peer learning opportunities.

For more information on dates and clinical areas covered, go to **coverahealth.com/webinar**.

Questions?

If you have questions about this program, contact Covera Health by calling 1-855-211-2272 or by sending an email message to bcbsmsupport@coverahealth.com.

Our commitment to quality

Blue Cross and BCN are proud to be leaders in advancing collaborative partnerships with our provider community to improve the quality, outcomes and value of care delivered to our members. This new radiology-focused initiative represents a significant step in fulfilling our commitment to our providers, our members and the communities we serve.

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.

Covera Health is an independent company that supports Blue Cross Blue Shield of Michigan and Blue Care Network by providing programs to help improve the diagnostic quality, quality of care and member outcomes related to radiology.

Reimbursement for certified opioid treatment programs to change in 2023

In the first quarter of 2023, we'll change how we reimburse providers who offer certified opioid treatment programs, or OTPs. The bundled reimbursement rates we use to reimburse for OTPs will include both the drug and nondrug components.

This change applies to providers who treat Blue Care Network commercial and BCN Advantage members diagnosed with an opioid use disorder.

Currently, the bundled rates we use to reimburse these services for BCN members include only the nondrug components. Providers bill the drugs separately.

We'll communicate the exact date of the change in an upcoming provider alert.

Reminder about OTP certification

As a reminder, only providers who are certified through the Substance Abuse and Mental Health Services Administration, or SAMHSA, to provide OTP services are eligible to receive bundled reimbursement.

OTPs provide medication-assisted treatment along with counseling and other services for people diagnosed with an opioid use disorder.

The treatment of opioid use disorders with medications is governed by the Certification of Opioid Treatment Programs, 42 Code of Federal Regulations 8. This regulation created a system to accredit and certify opioid treatment programs. SAMHSA's Division of Pharmacologic Therapies is responsible for overseeing the certification of OTPs.

Additional information

- For information on how to obtain OTP certification, visit SAMHSA's **Certification of Opioid Treatment Programs webpage**.
- For information on Medicare billing and payment guidelines for OTPs, refer to the fact sheet titled **Opioid Treatment Programs (OTPs) Medicare Billing & Payment (MLN Booklet 8296732)**.

We'll change how we cover some drugs, starting Feb. 1

Starting February 1, 2023, we'll change how we cover some medications on the drug lists associated with our prescription drug plans. These changes are listed below and apply for both the brand name and any available generic equivalents for drug lists where the drugs are currently covered. No changes will apply if a drug is currently not covered.

We'll encourage members to discuss their treatment options with their provider if they have any concerns.

Drug	Affected drug list	Common use	Coverage or requirement change
Bydureon® Byetta® Ozempic® Rybelsus® Trulicity® Victoza®	All (where the drug is currently covered)	Diabetes	Will have new coverage requirements for **members new to treatment.** Coverage will require the following: 1. Being used for the treatment of Type 2 diabetes. **OR** 2. Trial of one generic or preferred medication for the treatment of Type 2 diabetes.
Wegovy®	Preferred only	Weight management	Will have a higher copayment.
Clenpiq® Moviprep® Plenvu® Suprep® Sutab®	All (where the drug is currently covered)	Bowel preparation	Will have quantity limit of 2 fills per 365 days.

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

Xenpozyme™ and Zynteglo® to require prior authorization for Medicare Advantage members, starting Nov. 1

For dates of service on or after Nov. 1, 2022, we're adding a prior authorization requirement for Medicare Plus Blue and BCN Advantage members for the following medications:

- Xenpozyme (olipudase alfa-rpcp), HCPCS code J3590
- Zynteglo (betibeglogene autotemcel), HCPCS code J3590

Submit prior authorization requests through the NovoLogix® online tool.

These medications 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 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 Xenpozyme™ continued on Page 26

Submit prior authorization requests through the NovoLogix tool

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the **Register for webtools** webpage on **bcbsm.com/providers**.

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 this change 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.

Pemfexy® to require prior authorization for most members, starting Feb. 9

For dates of service on or after Feb. 9, 2023, Pemfexy (pemetrexed), HCPCS code J9304, 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 Care Network commercial members
- BCN Advantage℠ members
- Blue Cross commercial — Members who have coverage through UAW Retiree Medical Benefits Trust non-Medicare plans, fully insured groups, and members with individual coverage.

  Note: This requirement doesn't apply to other members who have coverage through Blue Cross commercial self-funded groups, including the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue℠ members

How to submit authorization requests

Submit 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 *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space where you'll click the *AIM Provider Portal* tile.
  - Logging in directly to the AIM ProviderPortal at **providerportal.com**.
- By calling 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, 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 pertinent 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.

Pharmacy News

Male condoms will be covered as a preventive care product, starting Jan. 1

Starting Jan. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will cover generic and select brand-name male condoms that comply with the Affordable Care Act's preventive care benefits requirements.

The amount that can be filled will be limited to 12 units per 30 days. Generic will be dispensed where available.

Members must obtain a prescription from a doctor for preventive care drugs, including over-the-counter drugs.

We're changing how we manage biologic asthma therapies, starting Jan. 1

Starting Jan. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network are changing how we manage some biologic asthma medications for all Blue Cross and BCN group and individual commercial members.

The following biologic asthma therapies will be affected by this change:

- Fasenra® (benralizumab), HCPCS code J0517
- Nucala® (mepolizumab), HCPCS code J2182

Fasenra and Nucala will continue to be covered under the medical benefit when administered by a health care professional. They'll be managed under the pharmacy benefit when self-administered.

Starting Jan. 1, these drugs will no longer be covered under the medical benefit when they're self-administered by a member.

Note: In October, we updated the medical policies for these drugs to reflect this change. You can view the medical policies through the **Medical Policy Router Search** page of the **bcbsm.com** website.

How to submit prior authorization requests

- When Fasenra or Nucala will be self-administered, submit the request using an electronic prior authorization, or ePA, tool such as CoverMyMeds® or Surescripts®.
- When Fasenra or Nucala needs to be administered by a health care professional, submit the request through the NovoLogix® online tool.

What you need to do for members who self-administer these drugs

- For members who self-administer these drugs and **don't** have pharmacy benefits through Blue Cross or BCN, providers need to work with the member's pharmacy vendor to ensure that the drug is covered.
- For members who self-administer these drugs and **do** have pharmacy benefits through Blue Cross or BCN, providers will need to submit a prior authorization request under the member's pharmacy benefit. Members can obtain these drugs through an AllianceRx Walgreens Pharmacy.

Why we're making this change

We're making this change as part of our continued effort to provide members with access to the best health care at the lowest cost. The management changes for this drug class ensure that we're taking the most cost-effective approach by reducing the cost to our members and to the plan. In addition, these changes ensure that patient health and outcomes aren't affected while delivering value to members.

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**.

For a full list of requirements related to drugs covered under the pharmacy benefit, see the **Prior authorization and step therapy coverage criteria**.

We'll update these lists to reflect the changes related to these drugs prior to the effective dates.

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

How BCN Advantage will reimburse carrier-priced codes, starting Jan. 1

Starting Jan. 1, 2023, BCN Advantage will follow Centers for Medicare & Medicaid Services guidelines when establishing reimbursement for procedure codes that CMS lists as carrier priced. This will apply to services for BCN Advantage members.

Definition of a carrier-priced code

A carrier-priced code is a CPT* or HCPCS code that has a specific description but for which CMS has not identified a fee. We include carrier-priced codes in our Medicare Advantage Professional Fee Schedule.

When there's no fee identified by CMS, BCN Advantage will establish the reimbursement for carrier-priced codes using the process outlined below.

Process for establishing the reimbursement for a carrier-priced code

Starting Jan. 1, 2023, BCN Advantage will follow these steps in the order listed below, to establish the reimbursement for a carrier-priced code:

1. We'll look at the fees published by one of these jurisdictional Medicare Administrative Contractors, or MACs:
   - Wisconsin Physician Services Government Health Administrators is the jurisdictional MAC providing Part A and Part B benefit administration for Indiana and Michigan. They publish the local carrier fees for professional services.
   - CGS Medicare, which publishes local carrier fees for durable medical equipment.
2. If we don't find a fee published by one of those jurisdictional MACs, we'll look at the BCBSM TRUST fee schedule.
3. If we don't find a fee in the BCBSM TRUST fee schedule, we'll base our reimbursement on a percentage of the billed charges, as defined in the provider agreement.

Additional information

Our Health Plan Medicare Advantage Professional Fee Schedule reflects locally adjusted reimbursement amounts established by CMS. We commit to timely implementation of any changes to our fee schedules based on changes to the CMS fee schedule, including carrier-priced codes, for payment to BCN Advantage members.

We won't retroactively adjust reimbursements to reflect these changes.

BCN updates billing and reimbursement information for mid-level, or nonphysician, practitioners

We've updated the Claims chapter of the BCN Provider Manual with the billing options and reimbursement information for mid-level, or nonphysician, practitioners for services to BCN commercial and BCN Advantage members.

The updates reflect the most current Blue Care Network reimbursement policies and apply to these practitioners:

- Acupuncturists
- Athletic trainers
- Clinical nurse midwives
- Clinical nurse specialists
- Clinical registered nurse anesthetists
- Dietary manager/dietitians
- Genetic counselors
- Nurse practitioners
- Physician assistants who are not employed by hospitals

Please see BCN updates billing continued on Page 29

To locate this information:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* and then click the BCBSM and BCN logo.
3. Select *Provider Manuals* on the Resources tab.
4. Click *BCN commercial and BCN Advantage* and then click *Claims (Billing)*.
5. Look for the section titled "Billing information for mid-level, or nonphysician, professional practitioners."

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

Medicare Plus Blue℠ and BCN Advantage℠ claims audits will transition from HMS to Cotiviti

Effective Dec. 1, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network will transition their audit services for Medicare Plus Blue and BCN Advantage claim reviews from HMS to Cotiviti, an independent company that provides auditing support services for Blue Cross and BCN. Cotiviti contracted with HMS in the past for clinical chart review services and has now purchased the company.

Here's how the transition will work:

- For reviews already in progress, all communication will continue under the HMS name until the reviews are complete. These claims will remain in the HMS portal.
- As of Dec. 1, 2022, communications will come directly from Cotiviti regarding completed reviews and new requests for medical records.

Note: During the transition, providers may receive communications from both HMS and Cotiviti for reasons stated above.

What you need to know

Cotiviti conducts clinical chart validation, or CVV, reviews to ensure proper billing. These require a copy of the medical records, which providers may submit medical records through the Cotiviti medical record upload portal or by mail. Cotiviti doesn't have a provider audit tracking portal at this time. Cotiviti has relationships established with several copy service companies including MRO, Ciox, and ScanStat, where they can acquire medical records electronically. Cotiviti also has relationships with some large provider groups that allows them to log in to their systems and retrieve electronic medical records.

Cotiviti typically sends medical records requests shortly after Blue Cross and BCN approve the selected claims to be audited, and sends reminders 30 days after the initial request. Final reminders are sent out 30 days after the reminder letter.

Audit and appeal determinations will be sent within 50 days after provider documentation, such as medical records, is received. The CVV includes instructions for requesting a review of the audit findings.

If you have questions, need additional information or to update provider contact information, please contact Cotiviti Provider Services at 770-379-2009 Monday thru Friday from 8 a.m. to 5 p.m. Eastern time.

If you didn't receive or misplaced audit correspondence, contact Cotiviti Provider Services, and they will mail you a copy of the correspondence through the U.S. Postal Service.

Coding Advisor outreach to educate providers about appropriate use of procedure codes

What you need to know

In January, Change Healthcare will reach out by phone or letter to health care providers who submit claims to Blue Cross Blue Shield of Michigan and Blue Care Network. Coding Advisor will compare the billing of CPT codes to the codes used by a provider's peers through a physician profile. (An example of a physician profiles is at the end of this article.)

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.

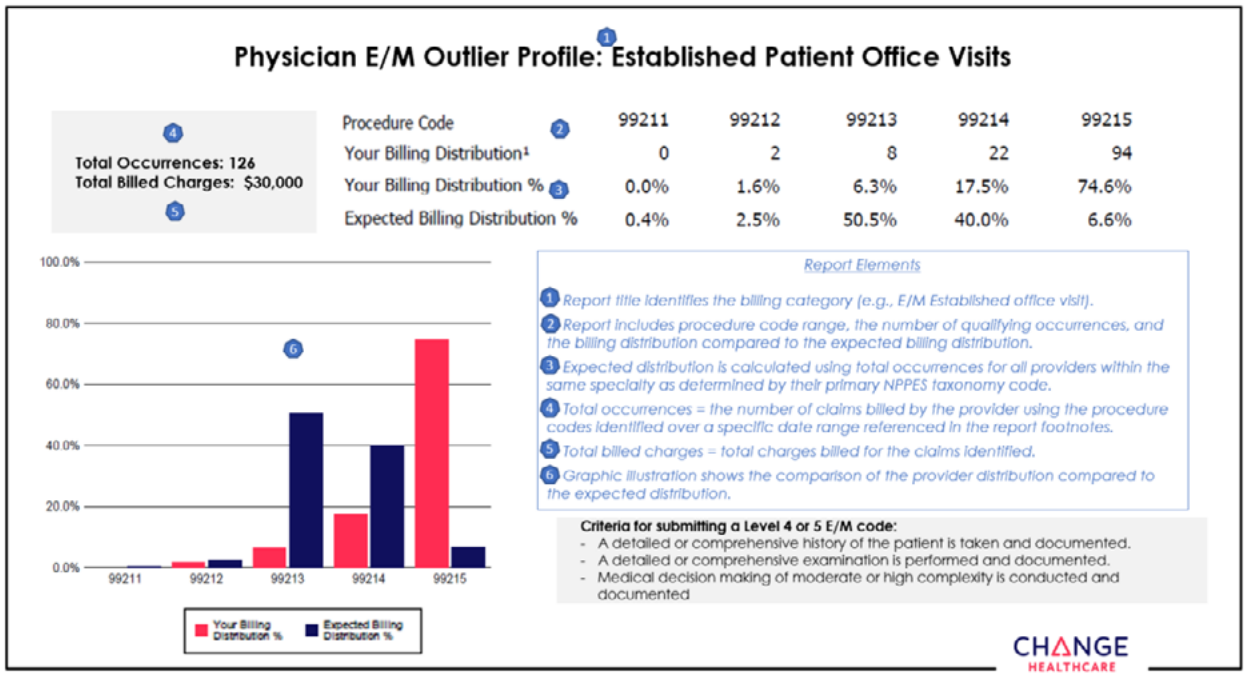
Change Healthcare reviews evaluation and management codes billed and other scenarios — such as use of modifier 25, observation care and nursing facility care — on claims submitted to Blue Cross. While Change Healthcare won't review Evaluation and Management services for BCN and BCN Advantage℠ because 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. The program provides useful data insights to the provider community and works to maximize coding efficiency and accuracy through up-front education, rather than taking a traditional post-claim review process.

Effective January 1, 2023, the Coding Advisor program will expand to include the review of Home Health services. The Home Health review is meant to help ensure the Domiciliary Rest Home or Custodial Care Services procedure codes *99324-*99337 and Home Services procedure codes *99341-*99350 are used and billed appropriately.

Throughout the course of this program, Coding Advisor will continue to monitor billing practices and send updated reports periodically. Coding Advisor 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, here's an example of a physician profile:



*CPT Copyright 2021 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

Updates related to swallow services for BCN

For swallow services, we:

- Reprocessed Blue Care Network commercial and BCN Advantage claims for swallow services that denied in error
- Are changing requirements for swallow evaluations for BCN commercial

Keep reading to learn more.

We reprocessed claims that denied in error for swallow services

For some providers, claims for the following procedure codes were denying in error for BCN commercial and BCN Advantage members:

- *92610 — Swallow evaluations
- *92611 through *92617 — Swallow studies
- *92526 — Swallow therapy

You don't need to take any action. We already reprocessed denied claims with dates of service on or after Jan. 1, 2021, that were affected by this issue.

In addition, we updated our systems so claims with these codes will no longer deny in error.

We apologize for the inconvenience and thank you for your patience.

Change to requirements for swallow evaluations for BCN commercial

For dates of service on or after Nov. 1, 2022, we no longer require contracted providers to submit plan notifications for swallow evaluations for BCN commercial members.

Note: This change doesn't affect BCN Advantage. Providers don't currently need to submit plan notification for swallow evaluations for BCN Advantage members.

As a reminder, contracted providers must continue to submit the following in the e-referral system for BCN commercial and BCN Advantage members:

- Plan notifications for swallow studies
- Prior authorization requests for swallow therapy

We updated the **BCN referral and authorization requirements for Michigan providers** document to reflect the change for swallow evaluations.

Note: Noncontracted providers must submit prior authorization requests for all services related to swallow therapy.

Billing changes coming for COVID-19 treatment products

Since the development of the COVID-19 treatment products, the U.S. government has provided these products at no cost to providers. Because of this, providers submitted claims to Blue Cross Blue Shield of Michigan or Blue Care Network only for the administration of the products.

As the remaining federal supply runs out, these products are transitioning to the commercial marketplace. After a product transitions, providers will need to purchase it and submit a claim to Blue Cross and BCN for both the product and the administration of the product.

Products already transitioned to the commercial marketplace

In August, a monoclonal antibody treatment drug, bebtelovimab, was successfully transitioned to the commercial marketplace. For Blue Cross commercial and BCN commercial members, member cost share may apply for this treatment.

Note: For Medicare Advantage members, we're waiving all cost sharing for monoclonal antibody products and administration until the end of the year in which the public health emergency ends, per the Centers for Medicare

Please see Billing changes continued on Page 32

& Medicaid Services requirements. Review the Dec. 17, 2021, **provider alert** for important information about billing Medicare Advantage plans for monoclonal antibody products and administration.

Expected time frame for additional products to transition to the commercial marketplace

According to the **Administration for Strategic Preparedness & Response**, this is the expected time frame for the following products to transition to the commercial marketplace:

- Evusheld, pre-exposure prophylaxis– early 2023
- Lagevrio, oral antiviral – first quarter 2023
- Paxlovid, oral antiviral – mid-2023

Additional information

For more information on COVID-19 vaccines, treatment, billing, etc., refer to our Coronavirus webpage. To access this page:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click the *Secure Provider Resources (Blue Cross and BCN)* link.
5. Click the *Coronavirus information* link under Easy Access.

You can also view these documents on our **public coronavirus webpage**.

Note: The U.S. Department of Health and Human Services is assisting providers who treat uninsured or underinsured patients with commercially purchased bebtelovimab by offering to replace the dose for free. HHS expects the supply for this **initiative** to last through September 2023.

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Reminder: Use U09.9 for long-term COVID-19 as a secondary diagnosis code

When treating patients for documented residual or long-term effects of COVID-19, use diagnosis codes for the specific symptoms. In addition, be sure to include U09.9 as a secondary diagnosis code. Including U09.9 is important for tracking the number of patients with long-term COVID-19.

More information about diagnosis codes for COVID-19 treatment is available in the **Billing tips for COVID-19** and **Billing tips for COVID-19 at a Glance** documents on our **COVID-19 webpage for health care providers**.

This information is also available on our provider portal. Here's how to find it:

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

None of the information included 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.

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Billing Bulletin

COVID-19 vaccine product coverage

When the government-purchased supply of COVID-19 vaccine product runs out, providers should bill the member's health plan for both administration and the vaccine product. We'll process claims based on members' immunization benefits.

As a reminder, you can view our COVID-19 provider communications as follows:

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

   Tip: You can make the Provider Resources site a favorite by clicking the heart icon next to this link. Clicking the heart adds a *Secure Provider Resources (Blue Cross and BCN)* link to the My Favorites menu.
5. Under Easy Access, click *Coronavirus information.*

You can also access these communications on our public website on the **COVID-19 webpage for health care providers** webpage.

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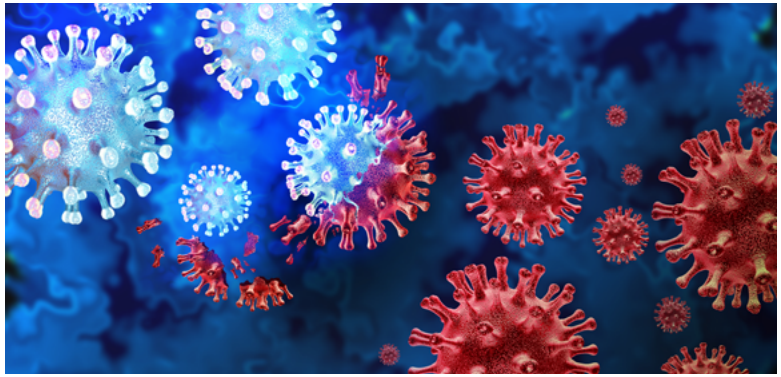

We're updating review threshold for high-dollar prepayments

What you need to know

Effective Jan. 1, 2023, high-cost claims greater than $75,000 are now eligible for high-dollar prepayment review by Blue Cross. This change only affects the review threshold. It doesn't affect any other aspect of the current high-dollar prepayment review process.

Since 2017, Blue Cross Blue Shield of Michigan has been partnering with Equian, an independent company, to review certain types of high-cost inpatient claims. This review helps us detect and resolve errors before payment to ensure that all claims will be paid right the first time.

As we **previously communicated**, Blue Cross intended to review high-cost claims greater than $25,000. But since beginning the review process in May 2017, we've only examined claims greater than $100,000. After five years of reviews at this higher amount, Blue Cross has decided to lower the review threshold.

Effective Jan. 1, 2023, high-cost claims greater than $75,000 are now eligible for high-dollar prepayment review by Blue Cross.

This change only affects the review threshold. It doesn't affect any other aspect of the current high-dollar prepayment review process, including claim payments and reconsideration time frames.

For more information:

- A detailed look at the process is available in the *BCN Provider Manual* under the "Reimbursement of high-cost inpatient claims" section of the Claims chapter.
- You can also read the previously published articles in the **April 2017** issue and **August 2017** issue of *The Record*, and the **March-April 2017 issue** of Hospital and Physician Update.

Billing Bulletin

BCN Provider *News*

Feedback

Clinical editing billing tips

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

This issue's tips:

- Modifier 26 No Longer Used to Support Denial of New Patient Claim
- Submitting a Clinical Editing Appeal for Lesions or Removals
- CPT Updates 2023
- Assistant Surgeon Appeals, What Documentation Should Be Submitted?

Clinical editing billing tips

Prior authorization and billing reminders for SNF interrupted stays for Medicare Advantage members

Per Centers for Medicare & Medicaid Services guidance, a skilled nursing facility interrupted stay occurs when a patient is discharged from a SNF and is readmitted to the same SNF within three consecutive days. When this occurs:

- The readmission or subsequent stay is considered a continuation of the previous stay.
- One claim must be submitted for both stays.
- The completion of new patient assessments is optional.
- The variable per diem isn't reset.

For more information, see the article on **Page 10**.

Ordering transfers from noncontracted (or nonparticipating) ambulance services costs members money

Providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers. This applies to transfers for Blue Cross commercial, Medicare Plus Blue℠, Blue Care Network commercial and BCN Advantage℠ members.

For more information, see the article on **Page 14**.

Reimbursement for certified opioid treatment programs to change in 2023

In the first quarter of 2023, we'll change how we reimburse providers who offer certified opioid treatment programs, or OTPs. The bundled reimbursement rates we use to reimburse for OTPs will include both the drug and nondrug components.

For more information, see the article on **Page 24**.

How to speed up the review process for AIM prior authorization requests

To make the process of submitting prior authorization requests to AIM Specialty Health® as speedy and efficient as possible, we're offering important tips to keep in mind. These tips apply to both initial requests and appeals.

What to do

- Gather all the pertinent information about the procedure and the patient's condition before submitting the request.

  Example: For requests that involve oncology services, include information on tumor testing results, tumor staging and previous therapy.

- Submit the request with a complete set of clinical information that supports the rationale for the treatment you're planning.

  Here's why: This will move the clinical review process along faster.

- Provide a phone number where the provider can be reached for a peer-to-peer discussion.

  Here's why: This will help AIM get answers to clinical questions so they can determine the medical necessity of the proposed services.

  Note: AIM physicians are available for peer-to-peer discussions **at any time** during AIM's business hours.

Submit authorization requests electronically

We encourage you to submit authorization requests to AIM through our provider portal. To do this:

1. Log in to **availity.com**.
2. On the Availity® menu bar, click *Payer Spaces* and then click the BCBSM and BCN logo.
3. On the Applications tab, click the *AIM Provider Portal* tile.

Note: If you need to request access to our provider portal, follow the instructions on the **Register for web tools** webpage on bcbsm.com/providers.

As an alternative, you can call the AIM Contact Center at 1-844-377-1278.

Where to find information about AIM requirements

For more information about the services that AIM manages for us, including procedure codes, and for more details on how to submit prior authorization requests to AIM, refer to these webpages at **ereferrals.bcbsm.com**:

- **Blue Cross AIM-Managed Procedures**
- **BCN AIM-Managed Procedures**
- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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.

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Prior authorization and billing reminders for SNF interrupted stays for Medicare Advantage members

Per Centers for Medicare & Medicaid Services guidance, a skilled nursing facility interrupted stay occurs when a patient is discharged from a SNF and is readmitted to the same SNF within three consecutive days. When this occurs:

- The readmission or subsequent stay is considered a continuation of the previous stay.
- One claim must be submitted for both stays.
- The completion of new patient assessments is optional.
- The variable per diem isn't reset.

For more information, see the article on **Page 10**.

Referral Roundup

Pemfexy® to require prior authorization for most members, starting Feb. 9

For dates of service on or after Feb. 9, 2023, Pemfexy (pemetrexed), HCPCS code J9304, will require prior authorization through AIM Specialty Health®. This drug is part of members' medical benefits, not their pharmacy benefits.

See the article on **Page 26** for details.

Updates related to swallow services for BCN

For swallow services, we:

- Reprocessed Blue Care Network commercial and BCN Advantage claims for swallow services that denied in error
- Are changing requirements for swallow evaluations for BCN commercial

See the article on **Page 31** for details.

New radiology-focused initiative aims to improve quality of care and member outcomes

Blue Cross Blue Shield of Michigan and Blue Care Network will be launching a radiology-focused quality improvement program in partnership with a third-party vendor. This program will help us better support radiologists and referring providers in their efforts to improve diagnostic quality, overall care and member outcomes.

See the article on **Page 22** for details.

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BCN Provider News

Point of service health plans don't require referrals

HMO plans require referrals
BCN's HMO health plans require: • The submission of referrals to BCN when the member's primary care physician is part of a medical care group headquartered in Michigan's East and Southeast regions • Referrals between physicians (but not submitted to BCN) in the Mid, West and Upper Peninsula regions
POS plans don't require referrals
BCN's POS health plans allow members to receive covered services with any health care provider, in or out of network, with no referral required

Blue Care Network offers two point-of-service health care plans: Blue Elect Plus℠ POS and Blue Elect Plus HSA℠ POS. In addition, beginning in 2023, BCN is administering a self-funded point-of-service health plan for FCA non-bargaining employees and retirees called Healthy Blue Choices℠ POS.

How do you know which of your BCN patients don't need a referral?

- While POS member ID cards have a Blue Care Network logo, they also include the health plan name, including "POS." POS plans don't require referrals.
- The back of POS plan ID cards also have a statement saying the POS plan doesn't require a referral in or out of network.
- When you check member eligibility and benefits in our provider portal, through an electronic transaction or by calling Provider Inquiry, you'll receive a message stating that the member can self-refer to any provider for covered services with no PCP referral required.

While referrals aren't required, patients with POS coverage will have lower out-of-pocket costs when they receive services from an in-network provider.

Some services are only covered when performed by in-network providers, and some services require authorization by BCN regardless of provider network status. More information is available on the **Blue Elect Plus POS** webpage and the **Healthy Blue Choices POS webpage**.

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BCN Provider *News*
Feedback

Provider Resources site adds new search tool

Search hint

To search for an entire phrase, or to make sure you get your specific keyword higher in the search results, put quotation marks around it.

Since launching our Blue Cross Blue Shield of Michigan and Blue Care Network Provider Resources site, we have continued to expand and improve it. We now have a search tool available to assist you in finding the information you need.

You'll find the search box in the upper-left corner of every page and can use it to search the entire site, including PDFs! Like many searches, the Provider Resources search will return results even if your spelling isn't quite right.

As a reminder, the Provider Resources site replaced the BCBSM Newsletters and Resources and the BCN Provider Publications and Resources sites when we moved to our new provider portal. It has information for all lines of business, including provider alerts, forms, provider manuals and more.

To get to the Provider Resources site:

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.

To get to the Provider Resources site more quickly, make it a favorite in Availity® Essentials. On the Resources tab within our Payer Space, click the heart icon next to *Secure Provider Resources (Blue Cross and BCN)*. You'll then be able to go directly to the Provider Resources site from the My Favorites dropdown in the top menu bar on any page of the 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.

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Reminder: Submit Healthy Blue Living℠ HMO qualification forms electronically

As a reminder, primary care physicians submitting the *Blue Care Network Qualification Form* for Blue Care Network members with health care coverage from *Healthy Blue Living℠ HMO*, Healthy *Blue Living HMO Basic℠* or BCN Wellness Rewards Tracking℠ must do so electronically through BCN Health e-Blue℠. BCN does not accept paper qualification forms.

Completing the form

If you need assistance filling out the form, please see the *Instructions for Completing the BCN Qualification Form*. This document can also be found within BCN Health e-Blue. 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 *Health e-Blue - BCN* under the *Applications* tab.
5. Locate the form under the *Healthy Blue Living Supporting Documents* section.

It can also be found on the Provider Resources site of 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* under the Resources tab.
5. Click on the *Products* drop-down menu. Select *BCN* and it is under the Healthy *Blue* Living section. You can also choose the *Forms* drop-down menu, select *Products*, then *Blue Care Network Commercial and Healthy Blue Living*.

Getting access to Health e-Blue or Availity

If you're not already signed up for Health e-Blue, go to the ***Register for web tools*** page and click on the *Set up Health e-Blue Tools* PDF. See *Task 3: Request access* to *Health e-Blue* through the *Blue Cross and BCN payer space in Availity*.

If you need access to Availity, see the ***Register for web tools*** page and follow the instructions.

Instructions for Completing the BCN Qualification Form

Know how to access and use RC Claim Assist through Availity Essentials

What you need to know

RC Claim Assist is available to Blue Cross Blue Shield of Michigan and Blue Care Network contracted health care providers through Availity Essentials to help them bill for drugs covered under the medical benefit.

This article was developed to provide information on how to access and use RC Claim Assist, a free web-based resource. RC Claim Assist provides:

- An overview of medical drug products
- A calculation tool to identify the correct National Drug Code and CPT codes to bill
- The correct NDC quantity to bill
- The unit of measure and HCPCS billable units according to the package information

How to access RC Claim Assist

Here's how to find RC Claim Assist within Availity Essentials:

1. Go to **availity.com** and log in to your provider portal.
2. Select *Payer Spaces* on the menu bar.
3. Click on the BCBSM and BCN logo.

Please see RC Claim Assist continued on Page 4

4. Go to the *Applications* tab.
5. Click on *RC Claim Assist* medical drug coding tool.
6. Click on Select a *Provider*.
7. Click on *Submit*.

Tips to help you use RC Claim Assist

You can use any of the following starting points to retrieve the conversion between HCPCS or CPT and NDC:

- HCPCS or CPT code
- NDC code
- Drug name

Refer to the tool only as a general reference and in conjunction with other resources, such as applicable fee schedules.

Note: Average wholesale price displayed is for reference only and doesn't reflect the actual reimbursement in claims processing.

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

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

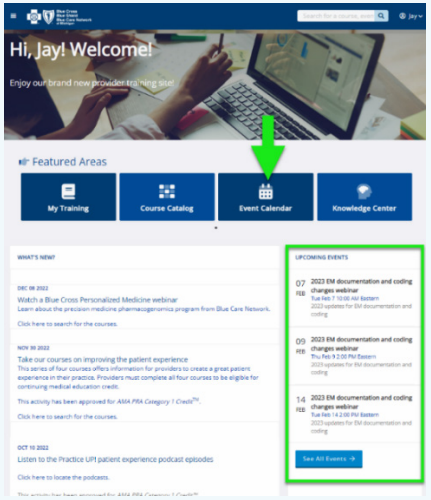
Beginning in April 2023, we will be offering webinars that will provide updated information on documentation and coding of common challenging diagnoses. These live lunchtime educational sessions will also include an opportunity to ask any questions that you may have.

Here's our current schedule and the tentative topics for the sessions. All sessions start at 12:00 p.m. Eastern time and generally last for 30 minutes. Log in to the provider training website and register for the session that best works with your schedule.

Session Date	Topic
April 26	HCC and Risk Adjustment coding scenarios
May 17	Coding Neoplasms
June 21	Coding diabetes and hypertension
July 19	Coding heart disease and vascular
August 16	Tips for proper medical record documentation and coding MEAT
October 18	ICD-10 CM updates and changes for 2024
November 15	Coding chronic kidney disease and rheumatoid arthritis
December 13	CPT coding scenarios; a look at the new CPT codes for 2024

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

After logging in to the provider training website, look in Event Calendar to sign up for the desired session.



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 needs. This will become your login ID.

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding registration, email ProviderTraining@bcbsm.com.

Register now for 2023 virtual provider symposium sessions

This year's virtual provider symposiums run throughout May and June. Physicians, physician assistants, nurse practitioners, nurses and coders can receive continuing education credits for attending. You're welcome to register for any session listed below.

Click here to log in to the provider training website to register for sessions.

You can easily create an account if you don't already have access: **click here to register**. We recommend that you use the same email address you use to communicate with Blue Cross Blue Shield of Michigan when creating the account.

Once you are logged in to the provider training site, open the event calendar to sign up for the desired sessions.

Reach for the Stars – HEDIS®/Star Measure Overview

For physicians and office staff responsible for closing gaps in care related to quality adult measures.

Reach for the Stars – HEDIS®/Star Measure Overview	Wed.	05/10/23	9-10:30 a.m.
Reach for the Stars – HEDIS®/Star Measure Overview	Thurs.	05/18/23	12-1:30 p.m.
Reach for the Stars – HEDIS®/Star Measure Overview	Tues.	05/23/23	2-3:30 p.m.
Reach for the Stars – HEDIS®/Star Measure Overview	Thurs.	06/01/23	8-9:30 a.m.
Reach for the Stars – HEDIS®/Star Measure Overview	Tues.	06/06/23	12-1:30 p.m.

Patient Experience

For physicians and office staff responsible for creating positive patient experiences. Learn how to ensure your practice has the knowledge and tools needed to set and meet patient's expectations.

Patient Experience – Best Practices for the New Normal	Tues.	05/02/23	9-10:30 a.m.
Patient Experience – Best Practices for the New Normal	Tues.	05/09/23	11:30 a.m.–1:00 p.m.
Patient Experience – Best Practices for the New Normal	Wed.	05/17/23	12-1:30 p.m.
Patient Experience – Best Practices for the New Normal	Mon.	05/22/23	2-3:30 p.m.
Patient Experience – Best Practices for the New Normal	Thurs.	06/08/23	9-10:30 a.m.

Coding Complex Cases

For physicians, coders, billers, and administrative staff.

Coding Complex Cases	Thurs.	05/04/23	9-10:00 a.m.
Coding Complex Cases	Thurs.	05/11/23	12-1:00 p.m.
Coding Complex Cases	Tues.	05/16/23	2-3:00 p.m.
Coding Complex Cases	Wed.	06/07/23	9-10:00 a.m.
Coding Complex Cases	Tues.	06/20/23	12-1:00 p.m.

Questions: Contact Ellen Kraft at ekraft@bcbsm.com if you have questions about the sessions. Contact the provider training team at ProviderTraining@bcbsm.com for questions about registration or using the provider training website.

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 new training resources for health care providers and staff. Our on-demand courses can help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

We recently added the following learning opportunities:

- **HCPCS and revenue code combinations:** This updated course shows you how to use reference tools to complete and troubleshoot Blue Cross commercial facility claims, addressing the transition to our new provider portal.
- **Patient experience eLearning:** This new course reviews best practices for improving the overall experience of your patients. See **this article**, in the January 2023 issue of *The Record*, for complete details.

As a reminder, we also have courses available to physicians for continuing education credit. These include:

- CMS Star measures overview
- Patient experience podcast series called "Practice Up!" (See **this article** in the December 2022 *Record* for details.)

Check the dashboard on our provider training site for announcements of what's available as we add more CME offerings to enhance the training experience for health care providers and staff.

Complete the following steps to request access to the training site:

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.

New, engaging patient experience e-learning course now available

Action item

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

Many of you have been asking for a self-directed, virtual approach to learning best practice tips, tools and techniques for improving the patient experience in personal and office interactions with patients. We've responded by developing a patient experience e-learning course, consisting of four modules.

The four modules include:

- Understanding the patient experience
- The changing expectations of consumers
- The importance of clear communication in setting expectations and building relationships
- The impact of the patient experience on health outcomes and tips for turning a good patient experience to a great one

The series is informative, engaging, fun and respectful of your busy schedules. It takes on average about 15 minutes to complete a module.

The modules have been reviewed and enthusiastically endorsed by a variety of our stakeholders, including physicians, physician organization staff and provider office staff. They're available for clinical and non-clinical staff on our provider training site. We encourage you to go through the modules individually or as part of a team in the office.

To register for and access provider training site

To request access to the site (if you haven't already registered) or to link to the site, follow these 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.

Continuing education credits

The Minnesota Medical Association designates this activity for a maximum of 2 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Patient experience podcast series

As a reminder, be sure to check out our patient experience podcasts. For complete details, see the December 2022 *Record* **article**.

Additional precision medicine and pharmacogenomics education opportunities

Action item

Visit our provider training site to watch previously hosted sessions.

On Jan.1, 2023, Blue Care Network launched an end-to-end precision medicine pharmacogenomics, or PGx, program called Blue Cross Personalized Medicine℠. The program was announced in the **July-August 2022 issue of *BCN Provider News***.

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. Visit our provider training website to register. Prescribers, clinical pharmacists and supportive staff are welcome to attend.

Session date/time	Case study focus	CME credit
Monday, March 27, 8 a.m. Eastern time	Cardiology	Yes
Wednesday, April 26, noon Eastern time	Oncology	No
Wednesday, May 24, 8 a.m. Eastern time	Behavioral Health	No

Access to the provider training website

- Click **here** if you are already registered for the provider training website.
- Click **here** to request access to the provider training website.
  1. Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan and Blue Care Network for other provider-related needs. This will become your login ID.
  2. Follow the **link** to log in.
  3. On the main page, click on the webinar event you wish to attend under Upcoming Events on the right side of the page.
  4. Click the Register button to complete your registration. You may either click the Add to your calendar button on the confirmation page or open the calendar attachment on your confirmation email to add the event to your email calendar.

Sessions will be recorded. If you're unable to attend, you can visit our provider training website to watch the previously hosted sessions. To watch the recorded sessions, visit the provider training website. Use the words PGx or personalized to search for the sessions.

Statement of Accreditation:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of Michigan State Medical Society and Blue Care Network of Michigan. The Michigan State Medical Society is accredited by the ACCME to provide continuing medical education for physicians.

AMA Credit Designation Statement:

The Michigan State Medical Society designates this live activity for a maximum of 1 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nonclinical, transitional care program available to members discharged to additional post-acute care facilities

On Jan. 1, 2023, our nonclinical, transitional care program expanded to include members who are discharged to additional post-acute care facilities.

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

Fylnetra® requires prior authorization for Medicare Advantage members, starting Dec. 19

For dates of service on or after Dec. 19, 2022, Fylnetra® (pegfilgrastim-pbbk), HCPCS code J3590, requires prior authorization. This drug is part of members' medical benefits, not their pharmacy benefits.

Submit prior authorization requests through the NovoLogix® online tool.

See the article on **Page 20** for details.

Byooviz is no longer the preferred ranibizumab drug for Medicare Advantage members

Because Byooviz® is no longer the preferred ranibizumab drug for Medicare Plus Blue℠ and BCN Advantage℠ members, it's no longer a step therapy requirement when prescribing Lucentis®. As a result, providers no longer need to include clinical documentation showing that the patient has tried Byooviz when submitting prior authorization requests for Lucentis® with dates of service on or after Jan. 9, 2023.

See the article on **Page 23** for details.

Leqembi to require prior authorization for Medicare Advantage members starting Jan. 13

For dates of service on or after Jan. 13, 2023, we added a prior authorization requirement for Medicare Plus Blue℠ and BCN Advantage℠ members for Leqembi™ (lecanemab-irmb), HCPCS code J3590.

See the article on **Page 24** for details.

Generic pemetrexed requires prior authorization for Medicare Advantage members

For dates of service on or after Jan. 1, 2023, generic pemetrexed, HCPCS code J9314 requires prior authorization through AIM Specialty Health®.

See the article on **Page 24** for details.

Additional drugs to require prior authorization for Medicare Advantage members, starting March 1

For dates of service on or after March 1, 2023, the following drugs require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members. These drugs are part of members' medical benefits, not their pharmacy benefits.

- Rolvedon™ (eflapegrastim-xnst), HCPCS code J3590
- Stimufend® (pegfilgrastim-fpgk), HCPCS code J3590
- Vegzelma® (bevacizumab-adcd), HCPCS code J3590

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

Hemgenix® and Tzield™ require prior authorization for Medicare Advantage members starting Dec. 2

For dates of service on or after Dec. 2, 2022, we require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members for the following drugs covered under the medical benefit:

- Hemgenix® (etranacogene dezaparvovec-drlb), HCPCS code J3590
- Tzield™ (teplizumab-mzwv), HCPCS code J3590

Submit prior authorization requests through the NovoLogix® online tool.

See the article on **Page 26** for details.

Update: BCN Advantage professional claims require Medicare provider taxonomy codes

When submitting professional claims for services to BCN Advantage members, you must include the appropriate Medicare provider taxonomy codes.

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

Reminder: Assessments and clinical documentation to submit for services received by Medicare Advantage members in SNFs

For Medicare Plus Blue and BCN Advantage members, skilled nursing facilities must submit certain items to naviHealth within specific time frames.

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

Provider-Delivered Care Management expands to BCN and BCN Advantage℠

Effective January 1, 2023, if you are a Patient-Centered Medical Home designated provider, or mid-level provider billing under a PCMH-designated provider, you can bill for provider-delivered care management services for Blue Care Network and BCN Advantage members.

You can now use the same PDCM codes you currently use with your Blue Cross Blue Shield of Michigan PPO members for your BCN and BCN Advantage members.

These codes are:

- HCPCS Codes: G9001, G9002, G9007, G9008, S0257
- CPT Codes: *98961, *98962, *98966, *98967, *98968, *99487, *99489

We published an introductory article about PDCM in the **Jan.-Feb. 2023 issue of *BCN Provider News*, on page 16**.

As mentioned in the article, some self-funded employer groups may elect to not participate with the PDCM program. FCA's new Healthy Blue Choices℠ POS health plan has chosen not to participate in PDCM.

If you have questions about PDCM, you can contact valuepartnerships@bcbsm.com.

Nonclinical, transitional care program available to members discharged to additional post-acute care facilities

In 2021, 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 who are discharged from inpatient acute care facilities in Michigan directly to their homes or to certain post-acute care facilities.

On Jan. 1, 2023, this program expanded to include members who are discharged to additional post-acute care facilities. To view the list of post-acute care facilities that participate in this program, see this **provider alert**.

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

naviHealth is an independent company that provides select care management services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Let's focus on providing a stellar patient experience

This is the first in a series of articles on the patient experience and why it matters to health care providers.

Beginning this month and running through May, our members — your patients — will be asked to complete the annual CAHPS member survey. CAHPS, which stands for Consumer Assessment of Healthcare Providers and Systems, asks patients to report on a wide range of health care services they receive. A large portion of the CAHPS survey is driven by the patient's experience with his or her primary health care provider and the provider's health care team, including such factors as the ability to get timely doctor's appointments and follow-up on labs and imaging.

That's why it's so important for health care providers to focus on the patient experience. Patients who experience high-quality care and services from their doctor and health care team are more likely to be satisfied, loyal patients who make regular appointments and adhere to their treatment plans. This leads to healthier patients, better health care outcomes and, overall, lower health care costs since chronic conditions are better managed when a patient sees a primary care physician regularly.

How to improve the patient experience

What exactly can practices do to improve the patient experience? Here are some guidelines:

- Provide timely and appropriate screenings, tests and treatment.
- Educate staff members on how to properly document care that's being 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.
- Coordinate 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.

New tools you can use

Our 2021 Blue Cross Blue Shield of Michigan physician survey showed that only 6 in 10 providers believe that Blue Cross is providing sufficient support to practices to help them improve the patient experience. That's why we've ramped up our support for providers in this area over the past two years.

Here are a few examples:

- A podcast series called "Practice Up." The four podcasts included in the series give providers concrete steps they can take to improve the patient experience. For complete details, see **this article** in the December 2022 *Record*.
- A four-module patient experience e-learning course that gives providers best practice tips, tools and techniques for improving the patient experience. For details, see **this article** in the January *Record*.

Sessions on "Patient Experience: Best practices in the New Normal," offered in May and June 2023 as part of this year's virtual provider symposium. It will show physicians and staff how providing great experiences to their patients benefits their practice. For more details and registration information, see **this article** in the February *Record*.

These offerings are fun, engaging and respectful of your busy schedules. You can participate at your convenience and also receive continuing education credits.

CAHPS survey: A closer look

The CAHPS survey, administered by the Agency for Healthcare Research and Quality, is sent to a random sample of members every spring to measure their experience with their health plan, prescription drug plan, health care providers and office staff. Many providers have asked us what kinds of questions patients are asked on the CAHPS survey.

Here's a sampling of the questions members will be asked about their health care experience when they receive their survey:

- Using a 10-point scale, how would you rate all your health care in the last six months?
- How often was it easy to get the care, tests or treatment you needed?
- How often did you get an appointment as soon as you needed it?

Please see Patient Experience continued on Page 13

- How often did you see the person you came to see within 15 minutes of your appointment time?
- When a provider ordered a blood test, X-ray or other test for you, how often did someone from the provider's office follow up to give you results?
- Did you get the help you needed from this provider's office in managing your care among different providers and services?

Answers that members provide influence the overall CAHPS score that a health plan receives. This score, in turn, plays a big role in a plan's Medicare Star Ratings performance. CAHPS and Star Ratings are important to providers because they indicate how well patients think physicians and staff are performing in areas that matter most to them.

"Many CAHPS metrics assess patient interactions with physicians and care delivery, including access to care, communication with physicians and the exchange of information between physicians," said Sherri Dansby, director of Patient Experience. "Satisfied patients are more likely to trust physicians with their care and be more compliant with treatment plans, which can positively impact patient outcomes."

Over the past several years, the patient experience has played an increasingly important role in Medicare Star Ratings. In 2017, it represented 18% of our Star Ratings, but now accounts for 34% of our ratings.

The link between physician satisfaction and patient satisfaction

Dansby added that practices offering a positive patient experience can also benefit physicians and staff. Good relationships with loyal patients can decrease staff burnout, stress and turnover.

According to our 2021 physician survey, two-thirds of physicians (63%) reported feelings of burnout — levels that have more than doubled since 2017 — and 70% agree they struggle with staffing challenges. A total of 428 physicians responded to the survey.

We appreciate all you do to improve the patient experience and hope your ongoing efforts lead to higher levels of physician and staff satisfaction as well.

For information or to request a patient experience consultation, please email PatientExperience@bcbsm.com.

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

- Positron Emission Tomography (PET) for Oncologic Conditions
- Genetic Testing – NGS of Multiple Genes (Panel) for Malignant Conditions (Previous title: Genetic Testing – NGS Testing of Multiple Genes (Panel) to Identify Targeted Cancer Therapy)
- Assisted Reproductive Techniques
- Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Respiratory Disorders
- Magnetic Resonance Imaging for Detecting and Diagnosis of Breast Cancer
- Infertility Diagnosis
- Genetic Testing-Noninvasive Prenatal Screening For Fetal Aneuploidies, Microdeletions, Single-Gene Disorders and Twin Zygosity Using Cell-Free Fetal DNA
- Cognitive Rehabilitation
- Germline Genetic Testing for BRCA1, BRCA2, and PALB2 for Hereditary Breast/Ovarian Cancer Syndrome and Other High-Risk Cancers
- Dental General Anesthesia
- Bone Growth Stimulation: Electrical Stimulation of the Spine
- Bone Growth Stimulation: Electrical Stimulation of the Appendicular Skeleton
- Magnetic Resonance Angiography and Magnetic Resonance Venography
- Lipedema-Surgical Treatments
- Genetic Testing – BCR/ABL1 in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia
- Relizorb
- Gender Affirming Services
- Skin and Tissue Substitutes

Medical Policy Updates

Legislation removes barriers to using buprenorphine to treat people with opioid use disorder

For more information about the Mainstreaming Addiction Treatment Act, be sure to look for an upcoming column from Dr. Beecroft in the March-April issue of *Hospital and Physician Update*, which publishes March 15

The Omnibus Spending Bill, which passed in December, marked a step forward in addressing the problem of opioid use disorder. It included the Mainstreaming Addiction Treatment Act, which is a bipartisan effort that will help prevent overdoses, increase access to treatment and reduce stigma.

The act removes many barriers in the prescription of medications for medication-assisted treatment for opioid use disorder, specifically buprenorphine, the most commonly prescribed of the MAT medications. This medication, along with naltrexone and naloxone, are considered by many to be among the principal tools in the treatment of OUD.

However, medications are only part of the solution for treating people with OUD. Other approaches include:

- Psychotherapy
- Contingency management, a *therapy approach that aims to help a person decrease drug-related behaviors through positive motivation*
- Family and social support systems
- Community resources
- Support programs such as Nar-Anon

"Case management can also be an effective tool in helping to ensure continued engagement, removing barriers to treatment and identifying non-adherence to treatment early so patients can get back on track more quickly," said William Beecroft, M.D., medical director of behavioral health for Blue Cross Blue Shield of Michigan "One of the main hallmarks of successful treatment is the patient's continued engagement with the treatment program with no future use of the substance. OUD is a chronic illness, such as diabetes and heart disease, and needs to be addressed as such."

Behavioral health providers: Hold claims for dates of service on or after Jan. 1, 2023, with codes *99354 and *99355

Until further notice, behavioral health providers should hold claims for dates of service on or after Jan. 1, 2023, that contain procedure codes *99354 and *99355. These codes are for non-medical behavioral health prolonged services.

The American Medical Association terminated codes *99354 and *99355 effective Jan. 1, 2023. If you submit claims with these codes for dates of service on or after Jan. 1, 2023, they won't be accepted, even if the claims contain other, payable codes.

Claims with dates of service prior to Jan. 1, 2023, can still be billed with these codes.

We're working on identifying active codes that can be billed in place of the terminated codes. Once we have a solution:

- We'll communicate it in another provider alert.
- You'll be able to bill claims retroactive to Jan. 1, 2023.

This applies to all our lines of business:

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

We appreciate your patience as we work to develop a solution.

Behavioral health coverage for Healthy Blue Choices℠ POS

The new Healthy Blue Choices℠ POS health plan has behavioral health coverage that is not handled through Blue Care Network. It is handled through Beacon Health Options. Providers should call Beacon Health using the phone number on the back of the member's ID card and submit behavioral health claims directly to Beacon Health.

Behavioral health claims for Healthy Blue Choices POS submitted to BCN will be rejected with the following exceptions.

Behavioral health services billable to BCN for Healthy Blue Choices℠ POS
Certain services for patients with an autism diagnosis. Specifically: • Occupational, speech and language and physical therapy performed by a licensed, certified therapist for PT, OT, ST • Nutritional therapy • Genetic testing
Claims with a primary diagnosis code of medical
Developmental screening
Emergency services, ambulance, outpatient radiology, outpatient rehabilitation, and outpatient laboratory services with a behavioral health primary diagnosis
Neuropsychological exams and ancillary services such as evaluations and interviews
Psychiatric diagnostic evaluations

Substance use treatment and recovery services received through a **Michigan Blue Distinction Centers** that has a Substance Use Treatment and Recovery designation.

All other behavioral health services not listed in the table above should be billed to Beacon Health Options.

Healthy Blue Choices POS is a new self-funded health plan for FCA non-bargaining employees and retirees that became effective: Jan. 1, 2023. We announced this new health plan in our Jan.-Feb. 2023 issue on page 8. See **New! Healthy Blue Choices℠ POS now available to FCA employees**.

You can learn more on our ereferrals.bcbsm.com website on the **Healthy Blue Choices POS webpage**.

BCN to use updated InterQual® ABA criteria starting March 1

Starting March 1, 2023, the Blue Care Network Behavioral Health department will use updated InterQual® applied behavior analysis criteria when making determinations on prior authorization requests for ABA services. This will apply to BCN commercial members undergoing autism therapy.

The most significant updates to the criteria are outlined in the following table.

Service	Current criteria	Updated criteria
Parent / caregiver training	Training must occur once every three or four weeks with 80% or greater attendance.	The parent or caregiver is adequately participating in treatment and training sessions. **Important:** The footnotes in the InterQual criteria are not specific about what constitutes adequate parent/caregiver training in terms of frequency or duration. However, the BCN Behavioral Health department staff and medical director will consider training to be adequate when it occurs at least one hour per month.
ABA treatment: recommended number of hours per week	A certain number of line therapy hours per week are suggested based on whether criteria were met or not met.	The recommended amount of line therapy is based on the severity of the developmental delay or problem behaviors exhibited by the member in conjunction with the number of hours per week they are involved in school or work or a similar program activity. **Important:** The severity is categorized as mild, moderate, or severe, and general guidelines for these severity categories can be found in the InterQual criteria footnotes. The number of hours authorized: • Can range from 10 hours per week for members with mild symptoms who are involved in full-time school/work/similar program activity to 40 hours per week for members who are not involved in school/work/similar program activity • Depend on the member's age, as well

Contact the Behavioral Health department at 1-800-482-5982 if you have questions or if you want to request a copy of the updated ABA criteria we'll use starting March 1, 2023.

Outpatient ECT won't require prior authorization for BCN members, starting Jan. 1

For dates of service on or after Jan. 1, 2023, Blue Care Network will no longer require prior authorization for outpatient electroconvulsive therapy, or ECT.

This change will apply to BCN commercial and BCN Advantage members.

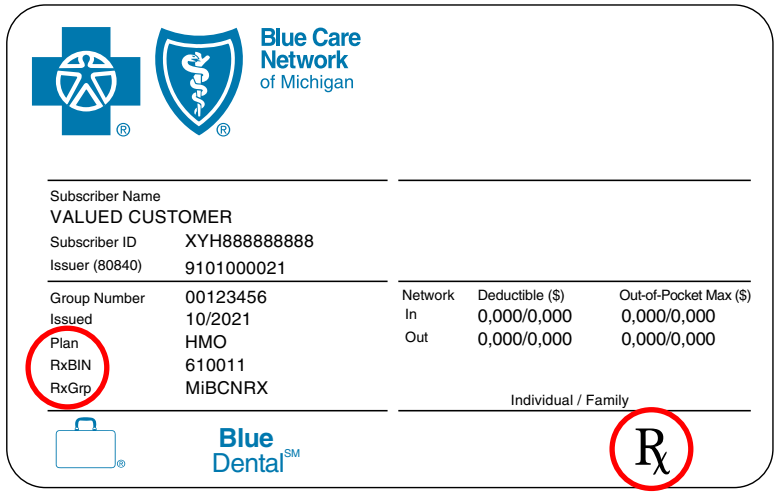
Prior to Jan. 1, we'll update the following documents to reflect this change:

- **Behavioral Health chapter** of the *BCN Provider Manual*
- **BCN referral and authorization requirements for Michigan providers** document

Reminder: Not all members have pharmacy coverage handled by BCN

Check the member's ID card to see if their Blue Care Network coverage includes pharmacy. If pharmacy is covered by BCN, you'll see an Rx graphic in the lower right corner of the ID card and an RxBIN number will be included.

If pharmacy is not covered by BCN, ask the member if they have a separate ID card for pharmacy coverage. Any requests for prescription drug coverage submitted to BCN for members whose pharmacy benefit is covered through a different company will be denied.



Example

Healthy Blue Choices℠ POS

The new Healthy Blue Choices POS health plan has pharmacy coverage that is not handled through Blue Care Network. Members with Healthy Blue Choices POS coverage have a separate ID card for pharmacy coverage. Providers and pharmacies should make sure to request a copy of the member's pharmacy ID card and follow instructions on that card.

More information

Healthy Blue Choices POS is a new self-funded health plan for FCA non-bargaining employees and retirees that became effective Jan. 1, 2023. We announced this new health plan in our Jan.-Feb. 2023 issue on page 8. See "**New! Healthy Blue Choices℠ POS now available to FCA employees**."

You can learn more on our ereferrals.bcbsm.com website on the **Healthy Blue Choices POS webpage**.

Fylnetra® requires prior authorization for Medicare Advantage members, starting Dec. 19

For dates of service on or after Dec. 19, 2022, Fylnetra® (pegfilgrastim-pbbk), HCPCS code J3590, requires prior authorization. This drug is part of members' medical benefits, not their pharmacy benefits.

Submit prior authorization requests through the NovoLogix® online tool.

When prior authorization is required

This medication requires prior authorization when it's administered by a health care provider in sites of care such as outpatient facilities or physicians' offices and is 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

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the Register for webtools webpage on **bcbsm.com/providers**.

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 Fylnetra.

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

AIM doesn't require prior authorization for 29 medical oncology drugs for most members starting Jan. 1

For dates of service on or after Jan. 1, 2023, we don't require prior authorization from AIM Specialty Health® for the 29 medical oncology drugs listed later in this article. These drugs are 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 who have coverage through self-funded groups that have opted in to the medical oncology program. Refer to the **AIM medical oncology prior authorization program opt-in list for Blue Cross commercial self-funded groups**.
  - Members with individual coverage
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

Which drugs are affected by this change?

The following drugs are affected by this change.

HCPCS code	Brand name	Generic name
J9042	Adcetris®	brentuximab vedotin
J9302	Arzerra®	ofatumumab
J9118	Asparlas™	calaspargase pegol-mknl
J9036	Belrapzo™	bendamustine hcl

Please see AIM continued on Page 19

Pharmacy News

HCPCS code	Brand name	Generic name
J9034	Bendeka®	bendamustine hcl
J9229	Besponsa®	inotuzumab ozogamicin
J9037	Blenrep™*	belantamab mafodotin-blmf
J9039	Blincyto®	blinatumomab
J9308	Cyramza®	ramucirumab
Q2050	Doxil®	doxorubicin liposomal
J9246	Evomela®	melphalan
J9301	Gazyva®	obinutuzumab
J9179	Halaven®	eribulin
J9325	Imlygic®	talimogene laherparepvec
J9318, J9319	Istodax®	romidepsin
J9207	Ixempra®	ixabepilone
J9043	Jevtana®	cabazitaxel
J9047	Kyprolis®	carfilzomib
Q2049	Lipodox®	doxorubicin liposomal
J2562	Mozobil®	plerixafor
J9203	Mylotarg™	gemtuzumab ozogamicin
J9295	Portrazza®	necitumumab
Q2043	Provenge®	sipuleucel-t
J2860	Sylvant®	siltuximab
J9033	Treanda®	bendamustine hcl
C9399	Unituxin®	dinutuximab
J0897	Xgeva®**	denosumab
J9400	Zaltrap®	ziv-aflibercept
J9223	Zepzelca™	lurbinectedin

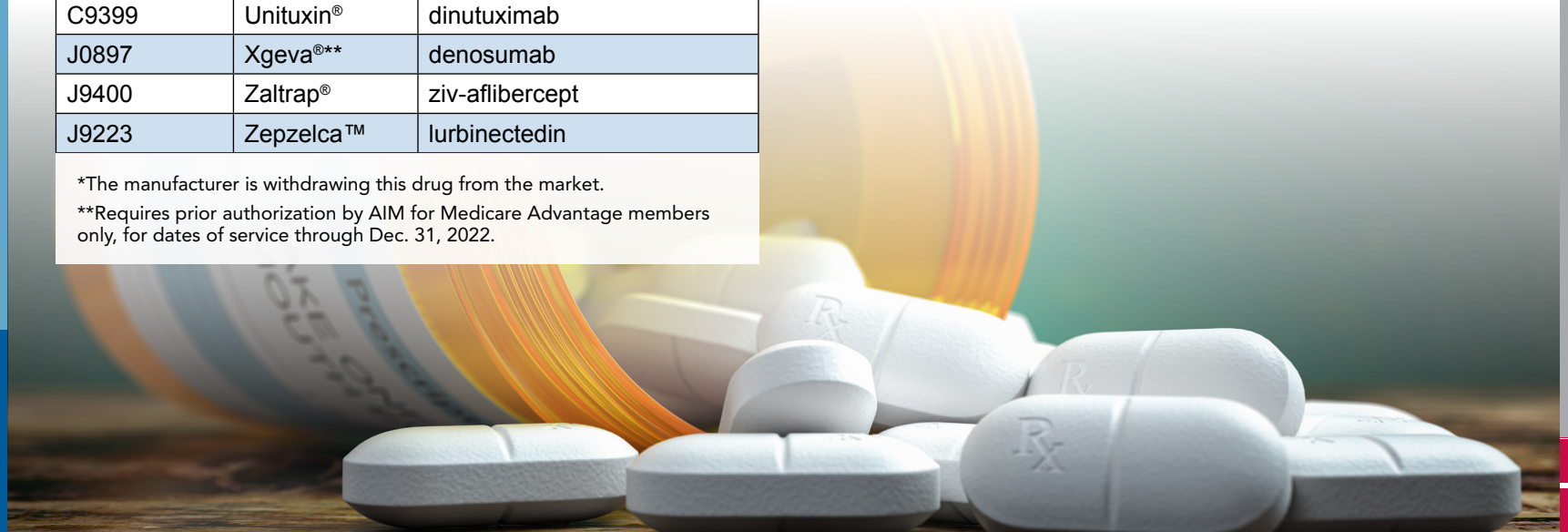
*The manufacturer is withdrawing this drug from the market.

**Requires prior authorization by AIM for Medicare Advantage members only, for dates of service through Dec. 31, 2022.

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**
- Medicare Plus Blue and BCN Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

We've updated the pertinent drug lists to reflect the changes outlined in this article.



Fylnetra and Rolvedon to require prior authorization for most commercial members starting March 13

Starting March 13, 2023, we're adding prior authorization requirements for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Fylnetra® (pegfilgrastim-pbbk), HCPCS codes J3590 and C9399
- Rolvedon™ (eflapegrastim-xnst), HCPCS codes J3590 and C9399

When submitting requests on or after March 13

Starting March 13, 2023, submit prior authorization requests for Fylnetra and Rolvedon through the NovoLogix® online tool. It offers real-time status checks and immediate approvals for certain medications.

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the **Register for webtools** webpage on **bcbsm.com/providers**.

When submitting requests before March 13

Before March 13, 2023, fax requests for preservice review as follows:

- Blue Cross commercial members: Fax to Provider Inquiry at 1-866-311-9603.
- BCN commercial members: Fax to the Medical Drug Help Desk at 1-877-325-5979.

Some Blue Cross commercial groups not subject to these requirements

For Blue Cross commercial groups, this authorization requirement applies only to groups that 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 the effective change of the change.

You can access this list and other information about requesting prior authorization on the following pages of the **ereferrals.bcbsm.com** website:

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

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 October through December 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	Requirement	
			Prior authorization	Site of care
J3590*	Hemgenix®	etranacogene dezaparvovec-drlb	P	
J0224	Oxlumo®	lumarisan		P
Q5125	Releuko®	filgrastim-ayow	P	
J2327	Skyrizi® IV	risankizumab-rzaa		P
J3590*	Skysona®	nivolumab and relatlimab-rmbw	P	
J3590*	Spevigo®	spesolimab-sbzo	P	
J3590*	Tzield™	teplizumab-mzwv	P	
J3590*	Xenpozyme™	olipudase alfa	P	

*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 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.

Xenpozyme and Spevigo to have site-of-care requirements for most commercial members starting March 1

For dates of service on or after March 1, 2023, we're adding site-of-care requirements for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Xenpozyme™ (olipudase alfa), HCPCS code J3590
- Spevigo® (spesolimab-sbzo), HCPCS code J3590

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for these drugs. If the request meets clinical criteria for the drug and is for one of the following sites of care, it 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 Xenpozyme or Spevigo in an outpatient hospital setting.

As a reminder, these drugs already require prior authorization; providers can submit prior authorization requests using NovoLogix. The new site-of-care requirements are in addition to the current prior authorization requirements.

Members who start courses of treatment with Xenpozyme or Spevigo before March 1, 2023, 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.

Some Blue Cross commercial groups not subject to these requirements

For Blue Cross commercial groups, the prior authorization and site-of-care requirements apply only to groups that 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 March 1, 2023.

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.

Byooviz is no longer the preferred ranibizumab drug for Medicare Advantage members

Because Byooviz® is no longer the preferred ranibizumab drug for Medicare Plus Blue℠ and BCN Advantage℠ members, it's no longer a step therapy requirement when prescribing Lucentis®.

As a result, providers no longer need to include clinical documentation showing that the patient has tried Byooviz when submitting prior authorization requests for Lucentis® with dates of service on or after Jan. 9, 2023.

Important: Both Byooviz and Lucentis continue to require that the member first try and fail Avastin® (bevacizumab), HCPCS code J3590 for Medicare Plus Blue and HCPCS code J9035 for BCN Advantage.

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

These drugs are covered under members' medical benefits.

Prior authorization still required

Both Byooviz and Lucentis continue to require prior authorization when administered by a health care provider in sites of care such as outpatient facilities or physician offices 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

Submit prior authorization requests through the NovoLogix® tool

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

To access NovoLogix, log in to our provider portal (**availity.com**), 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.

If you need to request access to Availity®, follow the instructions on the **Register for webtools** webpage at bcbsm.com/providers.

Reminder about requirements for other retinal drugs

All other intravitreal drugs for retinal conditions still have Avastin as a step therapy requirement. These drugs are:

- Eylea® (aflibercept), HCPCS code J0178
- Beovu® (rolucizumab-dbll), HCPCS code J0179
- Vabysmo® (facricimab-svoa), HCPCS codes J2777
- Susvimo™ (ranibizumab injection, for ocular implant), HCPCS code J2779
- Cimerli™ (ranibizumab-eqrn), HCPCS code J3590

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.

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

Leqembi requires prior authorization for Medicare Advantage members

For dates of service on or after Jan. 13, 2023, we're adding a prior authorization requirement for Medicare Plus Blue℠ and BCN Advantage℠ members for the following drug:

- Leqembi™ (lecanemab-irmb), HCPCS code J3590

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

When prior authorization is required

Leqembi will require prior authorization when it is administered by a health care provider in sites of care such as outpatient facilities or physician offices and is 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

To access NovoLogix, log in to our provider portal (**availity.com**), 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.

Note: If you need to request access to Availity®, follow the instructions on the **Register for webtools** webpage at **bcbsm.com/providers**.

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 this change prior to the effective date of this change.

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

Generic pemetrexed requires prior authorization for Medicare Advantage members

For dates of service on or after Jan. 1, 2023, the following drug requires prior authorization through AIM Specialty Health®:

- Generic pemetrexed, HCPCS code J9314

As a reminder, we previously communicated the following requirements for brand name drugs:

- Alimta® (pemetrexed), HCPCS code J9305, requires prior authorization through AIM.
- Pemfexy® (pemetrexed), HCPCS code J9304, requires prior authorization through AIM for dates of service on or after Feb. 9, 2023.

These requirements apply to Medicare Plus Blue and BCN Advantage members. These medications are part of members' medical benefits, not their pharmacy benefits.

When prior authorization is required

These drugs require prior authorization when they're administered by a health care provider in an outpatient facility or a physician's office 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

Please see Generic pemetrexed continued on Page 25

How to submit 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 *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space where you'll click the *AIM Provider Portal* tile.
  - Logging in directly to the AIM ProviderPortal at **providerportal.com**.
- By calling the AIM Contact Center at 1-844-377-1278

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 this change prior to 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.

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

Additional drugs to require prior authorization for Medicare Advantage members, starting March 1

For dates of service on or after March 1, 2023, the following drugs will require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members. These drugs are part of members' medical benefits, not their pharmacy benefits.

- Rolvedon™ (eflapegrastim-xnst), HCPCS code J3590
- Stimufend® (pegfilgrastim-fpgk), HCPCS code J3590
- Vegzelma® (bevacizumab-adcd), HCPCS code J3590

Submit prior authorization requests through the NovoLogix® online tool.

When prior authorization is required

These medications require prior authorization when they're 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 NovoLogix

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the **Register for webtools** webpage on **bcbsm.com/providers**.

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 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.

Pharmacy News

Hemgenix® and Tzield™ require prior authorization for Medicare Advantage members starting Dec. 2

For dates of service on or after Dec. 2, 2022, we require prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members for the following drugs covered under the medical benefit:

- Hemgenix® (etranacogene dezaparvovec-drlb), HCPCS code J3590
- Tzield™ (teplizumab-mzwv), HCPCS code J3590

Note: A prior authorization requirement also applies to most Blue Cross and Blue Shield of Michigan and Blue Care Network commercial members. See this **provider alert** for more information.

Submit prior authorization requests through NovoLogix®

Submit prior authorization requests for Hemgenix and Tzield through the NovoLogix online tool. It offers real-time status checks and immediate approvals for certain medications.

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the **Register for webtools** webpage on **bcbsm.com/providers**.

When prior authorization is required

These medications require prior authorization when they're 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

List of requirements

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

We've updated this list to reflect the change for Hemgenix and Tzield.

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.

Starting March 1, 2023, we'll no longer cover Vigadrone® powder packets

Starting March 1 Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover Vigadrone® powder packets on the pharmacy or medical benefit. Instead, we'll cover other generic vigabatrin powder packets. Vigadrone is a medication commonly used to treat certain types of seizures.

Both Vigadrone and vigabatrin are AB-rated generic equivalent products for Sabril® that were approved by the FDA via an Abbreviated New Drug Application. Both products are generic vigabatrin powder, but Vigadrone is approximately 10 times more expensive than other available generic products. It also requires limited distribution through PANTHERx, a nonpreferred specialty pharmacy, whereas the other generic products are available through specialty pharmacies. Our preferred specialty pharmacy is AllianceRx Walgreens Pharmacy.

If your patient requires treatment with Vigadrone rather than another generic product after March 1, a medical necessity review will be required.

We'll notify affected members of these changes and encourage them to talk with you about getting a new prescription if needed and any concerns they may have. If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803.

Update: BCN Advantage professional claims require Medicare provider taxonomy codes

When submitting professional claims for services to BCN Advantage members, you must include the appropriate Medicare provider taxonomy codes. Here's what to do.

For providers billing with a Type 2 (group) NPI

When billing BCN Advantage professional claims with a Type 2 (group) NPI, you must do both these things:

When billing electronically:

- Include the Medicare taxonomy code for the billing provider in loop 2000A of the electronic 837P claim transaction.
- Include the Medicare taxonomy code for the rendering provider, as applicable, in loop 2310B of the electronic 837P claim transaction.

When billing with the CMS-1500 paper claim form:

- Report the billing provider's taxonomy code and qualifier ZZ in box 33b.
- Report the rendering provider's Medicare taxonomy code in the first row of box 24J along with qualifier ZZ in box 24I.
- Report the rendering provider's NPI in the second row of box 24J.

Including the Medicare taxonomy code for both the rendering provider and the billing provider on professional claims billed with a Type 2 (group) NPI ensures that we can process these claims accurately and in a timely manner. It also meets the requirements of the Affordable Care Act and the Centers for Medicare & Medicaid Services.

BCN Advantage professional claims submitted without the Medicare taxonomy code for the rendering provider will be denied. You'll need to resubmit them with the Medicare taxonomy code for the rendering provider included.

For providers billing with a Type 1 (individual) NPI

When billing BCN Advantage professional claims with a Type 1 (individual) NPI, you must:

- Include the Medicare taxonomy code for the billing provider in loop 2000A of the electronic 837P claim transaction.
- Report the billing provider's taxonomy code and qualifier ZZ in box 33b of the 1500 paper claim form.

BCN Advantage professional claims submitted without the Medicare taxonomy code for the billing provider will be denied. You'll need to resubmit them with the Medicare taxonomy code.

Additional information about Medicare provider taxonomy codes

For more information about Medicare provider taxonomy codes, refer to the **Find Your Taxonomy Code** webpage at **cms.gov**.

Medicare provider taxonomy codes determine how providers are reimbursed for professional services for BCN Advantage members.

BCN to change inpatient readmission review guidelines starting June 1, 2023

Starting June 1, 2023, BCN will change the guidelines it uses to review inpatient readmissions of BCN commercial and BCN Advantage members for billing purposes.

Under the updated guidelines, BCN will review admissions for BCN commercial and BCN Advantage members readmitted within 30 days of discharge. Currently, BCN reviews admissions for members readmitted within 14 days of discharge.

These guidelines apply to facilities that are reimbursed by diagnosis-related groups, or DRGs. In some instances, BCN combines the two admissions into one for purposes of the DRG reimbursement.

You can access the current **Guidelines for Bundling Admissions** by following the steps below. We'll update that document before June 1 to reflect any changes.

1. Visit **ereferrals.bcbsm.com**.
2. Click *BCN*.
3. Click *Authorization Requirements & Criteria*.
4. Click *Guidelines for Bundling Admissions* under the "Referral and authorization information" heading and the "Acute inpatient care" subheading.

Watch for additional information about these changes in future *BCN Provider News* articles.

Reminder: Assessments and clinical documentation to submit for services received by Medicare Advantage members in SNFs

For Medicare Plus Blue and BCN Advantage members, skilled nursing facilities must submit certain items to naviHealth within specific time frames.

PT, OT, ST and nursing assessments

SNFs must submit physical therapy, occupational therapy, speech therapy and nursing assessments to naviHealth within 48 hours of a member's admission to a skilled nursing facility.

naviHealth uses these assessments to:

- Complete the nH Predict functional assessment
- Create and deliver the nH Predict outcome report to the member and the SNF in a timely manner

Clinical documentation and assessments for calculating CMG levels

By day seven of a member's stay, SNFs must submit the following items to naviHealth so they can calculate the case mix group, or CMG, level:

- PHQ-9 assessment
- Medication Administration Record, or MAR / Treatment Administration Record, or TAR
- Discharge planning assessment
- Physician and nursing notes
- Physical, occupational and speech therapy notes

naviHealth will calculate the CMG level within two days of receiving clinical documentation and assessments. They'll use the CMG level to generate patient-driven payment model, or PDPM, codes, which are used for billing.

Requirements for reassessments of CMG levels

After naviHealth has calculated the CMG level, SNFs can submit requests to reassess CMG levels. **Be sure to request the reassessment prior to discharging the member from skilled services**. Send the clinical documentation required for the reassessment to naviHealth as soon as possible.

Please see Assessments and clinical documentation continued on Page 29

Clinical documentation for the reassessment of CMG levels includes — but isn't limited to — information from the most recent history and physical, transfer documents, physician progress notes, discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and diagnostic reports.

naviHealth will use the clinical documentation to determine whether to change the CMG level. The provider must identify where the supporting documentation appears within the clinical documentation. If naviHealth determines that the CMG level should change, they'll change it retroactive to the day of admission.

You can use the *Request for a Reassessment of the CMG Level* worksheet to ensure that you submit comprehensive clinical documentation to support the request. You can find this worksheet:

- By requesting it from your assigned naviHealth Care Coordinator.
- Through the naviHealth resource website for Blue Cross and BCN at **https://partners.navihealth.com/partner/bcbsm**. If you haven't already registered for this website, see the "How do I access naviHealth documents related to this program?" section of the **Post-acute care services: Frequently asked questions for providers** document to learn how.

Note: The decision to change a CMG level may require review of the request by a naviHealth medical director.

Additional information

If you have questions about the information in this provider alert, contact your naviHealth Care Coordinator or your naviHealth Provider Relations Manager.

You can find more information in the **Post-acute care services: Frequently asked questions for providers** document. We updated this document to include the information in this provider alert.

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.

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 tip:

- Important Updates for Submitting a Clinical Editing Appeal

Clinical Editing Billing Tips

Behavioral health providers: Hold claims for dates of service on or after Jan. 1, 2023, with codes *99354 and *99355

Until further notice, behavioral health providers should hold claims for dates of service on or after Jan. 1, 2023, that contain procedure codes *99354 and *99355. These codes are for non-medical behavioral health prolonged services.

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

Behavioral health coverage for Healthy Blue Choices℠ POS

The new Healthy Blue Choices℠ POS health plan has behavioral health coverage that is not handled through Blue Care Network. It is handled through Beacon Health Options. Providers should call Beacon Health using the phone number on the back of the member's ID card and submit behavioral health claims directly to Beacon Health.

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

We added, updated and removed questionnaires in the e-referral system

In November and December 2022, we added, updated and removed questionnaires in the e-referral system. We also added, updated or removed 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:

- *Breast implant management* — For adult BCN Advantage members
- *Breast implant management* — For adult BCN commercial members

As part of this change, we removed the Breast implant management questionnaire that applied to both Blue Care Network commercial and BCN Advantage adult members.

Updated questionnaires

We updated the following questionnaires:

- *Breast reconstruction* — This questionnaire now opens only for adult BCN commercial members.

  Note: Although the *Breast reconstruction* questionnaire no longer opens for adult BCN Advantage members, breast reconstruction procedures continue to require prior authorization for these members.
- *Gastric stimulation* — We updated some of the questions in this questionnaire, which opens for adult Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ members.

Removed questionnaires

We removed the following questionnaires, which previously opened for adult and pediatric BCN commercial and BCN Advantage members:

- *Cardiac rehabilitation* — This questionnaire no longer opens for procedure codes *93797 and *93798.

  Although these procedure codes no longer require prior authorization, you need to submit plan notification because these services have benefit limits. Within the benefit limit, the e-referral system will automatically approve plan notification requests. Any requests received after the benefit limit has been exhausted won't be approved.
- *Cognitive rehabilitation* — This questionnaire, which is for adult and pediatric BCN commercial and BCN Advantage members, will no longer open for procedure code *97129.

  Note: Procedure code *97129 continues to require prior authorization. Submit prior authorization requests to eviCore healthcare® when the procedure is related to occupational therapy. Submit the request to BCN through the e-referral system when the procedure is related to speech therapy.
- *Pulmonary rehabilitation* — This questionnaire will no longer open for procedure codes G0237, G0238, G0239, G0302, G0303, G0304, G0424 and S9473.

  Although these procedure codes no longer require prior authorization, you need to submit plan notification because these services have benefit limits. Within the benefit limit, the e-referral system will automatically approve plan notification requests. Any requests received after the benefit limit has been exhausted won't be approved.

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.

Please see We added, updated continued on Page 31

- 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.

eviCore healthcare 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.

Updated fax forms for submitting prior authorization requests to TurningPoint for musculoskeletal procedures

On Nov. 22, 2022, Blue Cross Blue Shield of Michigan and Blue Care Network posted updated fax forms for use when submitting prior authorization requests to TurningPoint Healthcare Solutions, LLC.

We updated the forms as follows:

Prior authorization request form	Updates
Joint and spine procedures	• Added a Case urgency section (standard or expedited). • Specified that for procedures with policies that have smoking and BMI criteria, the requesting provider must include signed documentation stating that they have discussed the risks and benefits of the procedure related to smoking and elevated BMI, as appropriate.
Pain management: Epidural steroid injections	Added a Case urgency section (standard or expedited).
Pain management: Facet joint injection	Added a Case urgency section (standard or expedited).
Pain management: Neuroablation procedures	• Added a Case urgency section (standard or expedited). • Added the question: "Is this request for Iovera® (cryoablation)?"
Pain management: Sacroiliac joint injections	Added a Case urgency section (standard or expedited).

If you use fax forms to submit prior authorization requests to TurningPoint, be sure to incorporate the updated forms into your process.

You can find these forms and other useful resources on these 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.

Point of service health plans don't require referrals

Blue Care Network offers two point-of-service health care plans: Blue Elect Plus℠ POS and Blue Elect Plus HSA℠ POS. In addition, beginning in 2023, BCN is administering a self-funded point-of-service health plan for FCA non-bargaining employees and retirees called Healthy Blue Choices℠ POS.

How do you know which of your BCN patients don't need a referral?

See the article on **Page 1** for details.

BCN to use updated InterQual® ABA criteria starting March 1

Starting March 1, 2023, the Blue Care Network Behavioral Health department will use updated InterQual® applied behavior analysis criteria when making determinations on prior authorization requests for ABA services. This will apply to BCN commercial members undergoing autism therapy that's managed by BCN.

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

AIM doesn't require prior authorization for 29 medical oncology drugs for most members starting Jan. 1

For dates of service on or after Jan. 1, 2023, we don't require prior authorization from AIM Specialty Health® for 29 medical oncology drugs. These drugs are part of members' medical benefits, not their pharmacy benefits.

See the article on **Page 18** for details.

Fylnetra and Rolvedon to require prior authorization for most commercial members starting March 13

Starting March 13, 2023, we're adding prior authorization requirements for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Fylnetra® (pegfilgrastim-pbbk), HCPCS codes J3590 and C9399
- Rolvedon™ (eflapegrastim-xnst), HCPCS codes J3590 and C9399

See the article on **Page 20** for details.

Requirements changed for some commercial medical benefit drugs

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

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

Referral Roundup

Xenpozyme and Spevigo to have site-of-care requirements for most commercial members starting March 1

For dates of service on or after March 1, 2023, we're adding site-of-care requirements for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Xenpozyme™ (olipudase alfa), HCPCS code J3590
- Spevigo® (spesolimab-sbzo), HCPCS code J3590

See the article on **Page 22** for details.

BCN to change inpatient readmission review guidelines starting June 1, 2023

Starting June 1, 2023, BCN will change the guidelines it uses to review inpatient readmissions of BCN commercial and BCN Advantage members for billing purposes.

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

Reminder: Assessments and clinical documentation to submit for services received by Medicare Advantage members in SNFs

For Medicare Plus Blue and BCN Advantage members, skilled nursing facilities must submit certain items to naviHealth within specific time frames.

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

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BCN Provider News

Changes for the end of the COVID-19 public health emergency

On Jan. 30, 2023, the White House announced that it will end the public health emergency on May 11, 2023.

Blue Cross Blue Shield of Michigan and Blue Care Network enacted temporary measures to support providers and protect members during the COVID-19 pandemic. Now that the public health emergency is ending, you need to know which temporary measures are continuing and which are ending.

Please refer to our **Temporary changes due to the COVID-19 pandemic** document. We've been updating this as we determine which temporary changes become permanent and which will end.

Several temporary measures will continue after the public health emergency ends

Here are some examples of changes that are no longer temporary and will continue after the public health emergency ends:

- For all members in group or individual plans covered by the Patient Protection and Affordable Care Act, cost sharing will continue to be waived for both the COVID-19 vaccine product and its administration when the vaccine is provided in network.
- For all members, specific COVID-19 and influenza testing will continue to be payable in a physician office setting.
- For all members, durable medical equipment, prosthetics, orthotics and medical supplies can continue to be prescribed via telemedicine visits.

Coverage is ending for several temporary measures

Here are a few examples of temporary changes that are ending:

- Expanded laboratory networks – We return to our standard lab networks beginning May 12. Please direct any patients who need a COVID-19 test to an in-network lab. As a reminder, BCN and BCN Advantage℠ use JVHL labs. Medicare Plus Blue℠ uses JVHL, LabCorp or Quest Diagnostics labs.
- Over-the-counter COVID tests – During the pandemic we covered over-the-counter at-home rapid diagnostic COVID-19 tests for members with Blue Cross or BCN pharmacy coverage. This coverage ends with the public health emergency on May 11.

For other temporary measures that have ended, please see the **Temporary changes due to the COVID-19** pandemic document.

Please see Changes for the end continued on Page 2

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Resources

Here are some additional resources for information on the ending of the public health emergency.

- **What Do I Need to Know? CMS Waivers, Flexibilities, and the Transition Forward from the COVID-19 Public Health Emergency**
- **Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap**

Through May 11, we'll continue to update the **Temporary changes due to the COVID-19 pandemic** document as decisions are made.

As a reminder, you can view our COVID-19 provider communications as follows:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click 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*.

You can also access these communications on our public website on the **COVID-19 webpage for health care providers** webpage.

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

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Network Operations

EDI transitioning to Availity starting in 2023

Blue Cross Blue Shield of Michigan and Blue Care Network will move our electronic data interchange services, known as EDI, to Availity® beginning in August 2023.

The EDI transition affects HIPAA* electronic transactions. The transition will occur in phases, starting with claims (837) and remittance (835) transactions, but all electronic transactions will transition to Availity. Examples of electronic transactions include the electronic 837 claims, 835 electronic remittance advice, 270/271 eligibility and benefit, 276/277 claim status and 278 prior authorizations.

This transition includes electronic transactions for all Blue Cross and BCN fully insured and self-funded health plans. This includes:

- Blue Cross commercial, including the Federal Employee Program®
- Medicare Plus Blue℠, our Medicare Advantage PPO plan
- Blue Care Network commercial
- BCN Advantage℠, our Medicare Advantage HMO and POS plans
- Blue Cross® Complete

If you submit HIPAA EDI transactions to Blue Cross for payers other than Blue Cross and BCN and our health plans listed above, you'll need to find a new method to submit those transactions. Blue Cross Blue Shield of Michigan EDI will no longer accept non-Blue Cross and BCN health plan transactions once our EDI transitions to Availity.

Many of our EDI submitters and trading partners already submit to Availity's EDI clearinghouse for other health plans. In 2022, Blue Cross and BCN moved our provider portal to Availity's secure platform where you can find information for members associated with multiple health plans.

We expect the EDI transition to begin in August 2023.

Availity will handle all transition activities and will start sending communications to our EDI submitters and trading partners 90 to 120 days prior to the transition.

- If you use a submitter or trading partner to exchange electronic transactions with us, check with them to ensure they're working with Availity on this transition.
- If you currently submit HIPAA EDI transactions today directly to Blue Cross and believe we may not have your most up-to-date email on file, reach out to partnermanagement@availity.com to update your contact information.

If you have any questions about the EDI transition, send an email to partnermanagement@availity.com. Don't contact Blue Cross EDI.

*Health Insurance Portability and Accountability Act

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

Network Operations

Reminder: Provider Resources site has added a new search tool

Search hint

To search for an entire phrase, or to make sure you get your specific keyword higher in the search results, put quotation marks around it.

Our Provider Resources site has recently added a search tool to assist you in finding the information you need. You'll find the search box in the upper-right corner of every page and can use it to search the *entire* site, including PDFs! Like many searches, the Provider Resources search will return results even if your spelling isn't quite right.

As a reminder, the Provider Resources site replaced the BCBSM Newsletters and Resources and the BCN Provider Publications and Resources sites when we moved to our new provider portal. It has information for all lines of business, including provider alerts, forms, provider manuals and more.

To get to the Provider Resources site:

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.

To get to the Provider Resources site more quickly, make it a favorite in Availity® Essentials. On the Resources tab within our Payer Space, click the heart icon next to *Secure Provider Resources (Blue Cross and BCN)*. You'll then be able to go directly to the Provider Resources site from the My Favorites dropdown in the top menu bar on any page of the 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.

Reminder: Health care providers must confirm data every 90 days and attest in CAQH every 120 days

What you need to know

To remain listed in Blue Cross provider directories, including Find a Doctor, health care providers must re-attest every 120 days.

Have you confirmed data within the past 90 days and attested in CAQH within the past 120 days? CAQH is a nonprofit alliance of health plans and trade associations focused on simplifying health care administration. If health care providers don't re-attest with CAQH every 120 days, they won't be included in Blue Cross Blue Shield of Michigan provider directories. That includes our *Find a Doctor* search tool. That's why it's so important to perform this task.

Here are some other reasons to re-attest with CAQH:

- Ensure that your affiliation with Blue Cross isn't interrupted.
- Keep your contact information up to date.
- Make sure that claims payment isn't interrupted.

Regardless of whether providers are practicing at an office location or practicing exclusively in an inpatient hospital setting, they need to perform this attestation.

If you're practicing exclusively in an inpatient hospital setting, you must indicate it on your CAQH application. This information is used to determine whether full credentialing is required.

Blue Cross uses CAQH to gather and coordinate our practitioner credentialing information. All health care practitioners, including hospital-based providers, need to be registered with CAQH.

If you have questions about CAQH, call the help desk at 1-888-599-1771, or go to **CAQH.org**.

Network Operations

Change Healthcare portal created to help providers import medical records

Change Healthcare now offers eligible providers access to an online portal that allows the secure upload of requested medical records for the EquiClaim retrospective audits. EquiClaim is an independent company that provides auditing support for Blue Cross Blue Shield of Michigan and Blue Care Network conducting medical claim audits for our members.

As of January 2023, the portal allows for the submission of medical records only. Change Healthcare is working to expand the ability to upload other types of documents, such as appeals. The portal is protected health information-friendly and HIPAA compliant. It allows users to securely submit medical records to Change Healthcare at no cost to them.

Note: Change Healthcare has an agreement with copy service vendor MRO that excludes providers from using the portal if they're already in a contract with MRO. If providers have a contract with MRO, they should refer to the directions in the medical request letter on how to send in the record and not use the portal.

How to register for the portal

Register for portal access using **this link**:

- Select *Medical Attachments* when prompted on the *Product & Services Selection* page. Untick the solution on the left side.
- You'll receive a confirmation page once you fill out the facility information; wait 5 to 6 business days for completion. You'll receive a follow-up email with more steps to set a password for your secure account.

Portal instructions

You can access the Change Healthcare Attachments Solution at **attachments.changehealthcare.com/payment-integrity**.

1. Enter the email address registered to account.
2. Click on the link for *Payment Integrity* on the bottom right corner of the page or select *Payment Integrity* from the *Menu* heading in the top left corner of the screen.
3. Enter the Case ID for the documents you'll be uploading.
   - Case ID can be found on the Medical Records Request letter.
   - Case ID will be 12 characters in length.
4. Click on *Add Files* to select with documents to upload.
5. Click on *Submit*.

Questions?

If you have questions or need technical assistance, call 1-866-943-9579, option 1, from 8 a.m. to 4:30 p.m. Eastern time, Monday through Thursday. Please have your Tax Identification Number ready to provide to your support team member.

Network Operations

Meet Dr. Peter T. Graham – the new Chief Medical Officer of Blue Care Network

Blue Cross Blue Shield of Michigan and Blue Care Network are proud to announce Peter T. Graham, M.D. as the new Chief Medical Officer of Blue Care Network. Prior Chief Medical Officer Scott Betzelos, M.D., continues to focus his energies on BCN in the new role of vice president, HMO Strategy and Affordability, where he will explore innovative opportunities for the HMO.

Dr. Graham is a Michigan native, and an undergraduate degree holder from the University of Michigan. Following undergraduate studies, he was a staffer in the Michigan Governor's office, and then U.S. House of Representatives, before returning to medical school at Michigan State University. He completed residency training in Family Medicine at MSU/Sparrow.

Dr. Graham was a staff physician with Sparrow Medical Group, eventually becoming medical director of Sparrow's home care agency, then medical director of Physicians Health Plan. He spent five years as the Vice President overseeing Sparrow's employed physician group before returning to PHP as Chief Medical Officer for the last decade. He is still active in resident and medical student education.

Dr. Graham has been extensively involved in organized medicine and physician advocacy. He is a past president of the Michigan Academy of Family Physicians and spent eight years on the Michigan Board of Medicine, including three years as chairperson.

As a family medicine physician, Dr. Graham knows the importance of the primary care physician's role in coordinating member care.

"It's essential for BCN to maintain a strong partnership with our primary care physicians and practitioners. My goal is to support our PCPs so they can provide the best care to our members," said Dr. Graham.

"As a health maintenance organization, prevention is key. I understand that primary care takes the lead in helping our members stay healthy. In conjunction with primary care, specialty care physicians and ancillary providers are crucial for managing member health conditions. BCN is well known for having Michigan's largest HMO network of high-quality health care providers. I am excited to work with BCN's providers to support and maintain their focus on health care excellence."

Learn more about Blue Cross Personalized Medicine℠

Action item

Behavioral health providers can sign up to attend a live webinar. See the article on page xx of this issue.

We know you're busy caring for patients. We also know that you'll want to learn about Blue Cross Personalized Medicine℠, Blue Care Network's new precision medicine pharmacogenomics, or PGx, program. PGx can help you personalize medications for your patients.

Some of your patients may be invited to take a RightMed® PGx test at no cost to them. These patients may want your advice on whether they should take this test. And, once results are available, they'll want you to determine if their medications should change.

Here's how to find information on the new PGx program.

View a recorded webinar or sign up to attend a live webinar

The best way to learn about PGx is to attend a webinar or view a recorded webinar. If you missed the recent March webinar for cardiologists or the April webinar for oncologists, you can find these recordings as well as prior recordings for primary care and behavioral health providers on our provider training website.

- Already registered for the provider training website?
  1. **Log in**.
  2. On the main page, look at Upcoming Events on the right side of the page to register for a live webinar.
  3. To view previously recorded webinars, use "PGx" or "personalized" in the search.
- Not yet registered for the provider training website?
  1. **Complete the registration process**. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan and Blue Care Network for other needs. This will become your login ID.
  2. Follow steps 1 through 3 above.

Read about PGx

You can learn more about BCN's new PGx program through these sources:

- **We're moving forward with Blue Cross Personalized Medicine**, in the March-April 2023 issue of *Hospital and Physician Update*
- **The July-August 2022 issue of *BCN Provider News*, page 1**
- Visit **MyRightMed.com/BCBSM-providers**
- Visit our Blue Cross Personalized Medicine webpage for a list of frequently asked questions a clinician guide and a fact sheet. Here's how to find it:
  1. Log in to our provider portal (**availity.com**).
  2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
  3. Click the *Resources* tab.
  4. Click *Secure Provider Resources (Blue Cross and BCN)*.
  5. Click the dropdown next to Member Care in the menu bar and click on *Blue Cross Personalized Medicine*.

Questions?

Call OneOme at 1-844-663-6635 from 8 a.m. to 6 p.m., Eastern time, Monday through Friday or email support@oneome.com.

OneOme is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing services related to genetic testing.

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

Network Operations

Provider training site updates for webinars

The Provider Experience team has made a few enhancements to our webinars.

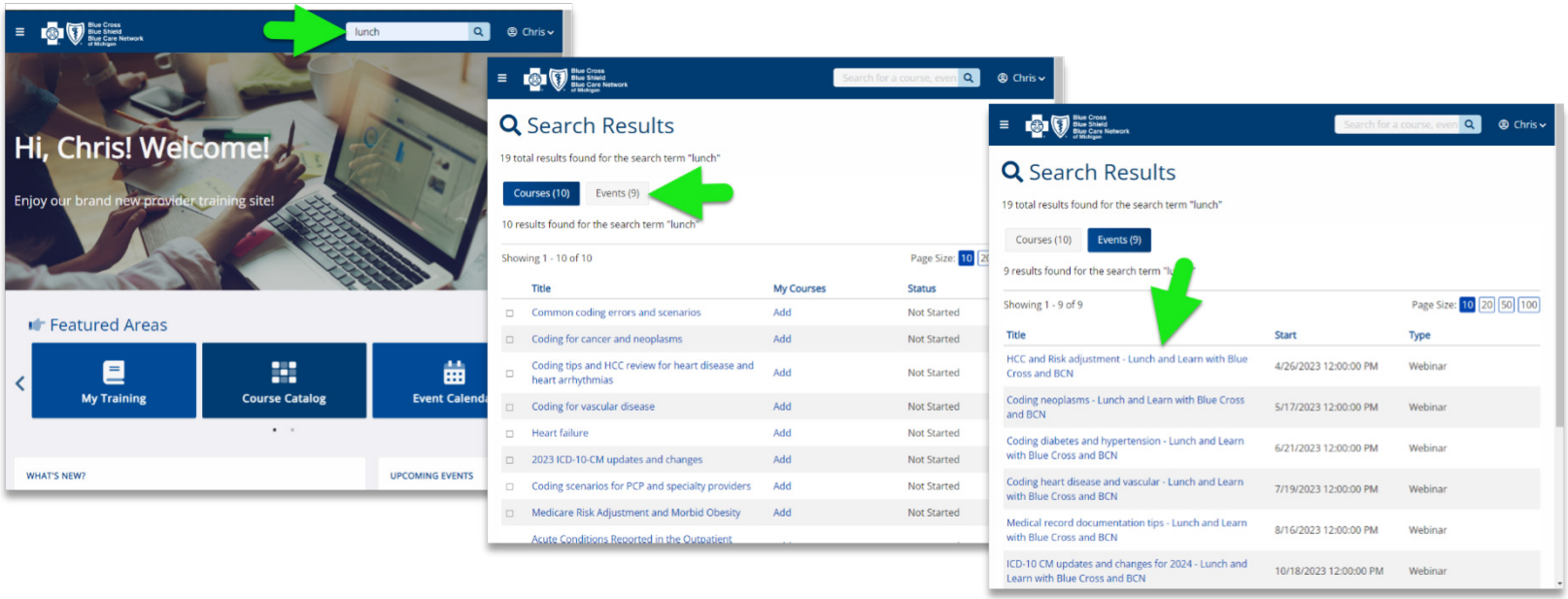
Action item

Experience our new features to sign up and attend upcoming webinars

Going forward, we will use the Microsoft Teams webinar platform to host all sessions. Participants who have a Teams account will see that their Teams ID is tracked whenever they join a session. If you do not have a Teams account, please use your full name and email address to sign in to your session.

All webinar events are now posted on the provider training website. You can register for sessions as soon as you see they are available.

Use the search feature to quickly locate the sessions that work with your schedule. Often, a keyword is all that is needed to locate the event. For example, use the term "lunch" to locate the 2023 Lunch and Learn events. After the search completes, click the Events tab to see the full list of sessions. Click the event title to register.



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

Click **here** to register for the provider training website. We recommend registering under the email you use to communicate with Blue Cross Blue Shield of Michigan and Blue Care Network for other provider-related needs. This will become your login ID.

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

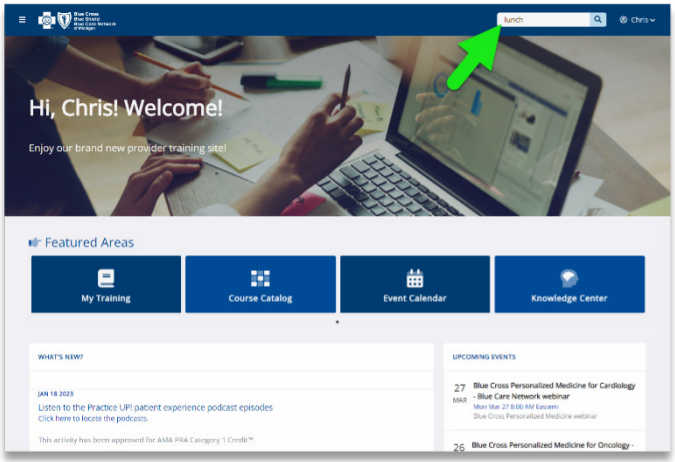
We are offering webinars that will provide updated information on documentation and coding of common challenging diagnoses. These live lunchtime educational sessions will also include an opportunity to ask any questions that you may have.

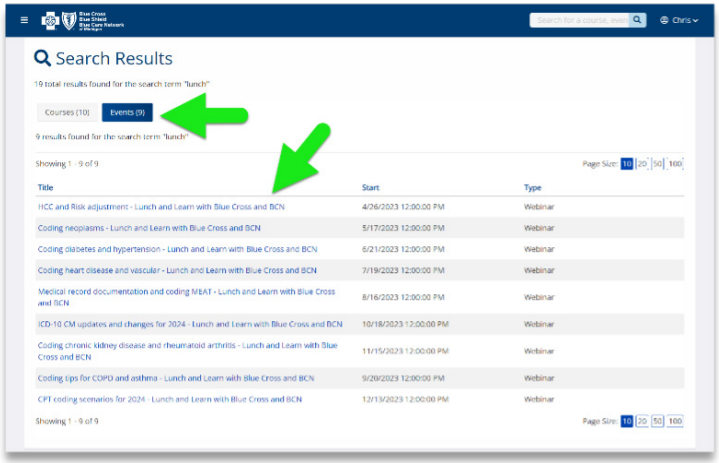
Here's our current schedule and the tentative topics for the sessions. All sessions start at noon Eastern time and generally last for 30 minutes. Log in to the provider training website and register for the session that best works with your schedule.

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

Session Date	Topic
May 17	Coding neoplasms
June 21	Coding diabetes and hypertension
July 19	Coding heart disease and vascular
Aug. 16	Tips for proper medical record documentation and coding MEAT
Sept. 20	Coding tips for COPD and asthma
Oct. 18	ICD-10 CM updates and changes for 2024
Nov. 15	Coding chronic kidney disease and rheumatoid arthritis
Dec.13	CPT coding scenarios; a look at the new CPT codes for 2024

On the provider training website, look in the Event Calendar or use the search feature with the keyword **lunch** to quickly locate all 2023 sessions.





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 needs. This will become your login ID.

You can also listen to the previously recorded sessions:

Previously recorded	Topic
April 26	HCC and risk adjustment coding scenarios

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding session or website registration, email ProviderTraining@bcbsm.com.

Reminder: Register now for 2023 virtual provider symposium sessions

This year's virtual provider symposiums run throughout May and June. Physicians, physician assistants, nurse practitioners, nurses and coders can receive continuing education credits for attending. You're welcome to register for any session listed below.

Click **here** to log in to the provider training website to register for sessions.

You can easily create an account if you don't already have access: Click **here** to register. We recommend that you use the same email address you use to communicate with Blue Cross Blue Shield of Michigan when creating the account.

Once you're logged in to the provider training site, open the event calendar to sign up for any of the following sessions.

Reach for the Stars-HEDIS®/Star Measure Overview: For physicians and office staff responsible for closing gaps in care related to quality adult measures.

Session	Date	Time
Reach for the Stars-HEDIS®/Star Measure Overview	May 10	9 to 10:30 a.m.
Reach for the Stars-HEDIS®/Star Measure Overview	May 18	12 to 1:30 p.m.
Reach for the Stars-HEDIS®/Star Measure Overview	May 23	2 to 3:30 p.m.
Reach for the Stars-HEDIS®/Star Measure Overview	June 1	8 to 9:30 a.m.
Reach for the Stars-HEDIS®/Star Measure Overview	June 6	12 to 1:30 p.m.

Patient Experience: For physicians and office staff responsible for creating positive patient experiences. Learn how to ensure your practice has the knowledge and tools needed to set and meet patients' expectations.

Session	Date	Time
Patient Experience – Best Practices for the New Normal	May 2	9 to 10:30 a.m.
Patient Experience – Best Practices for the New Normal	May 9	11:30 a.m. to 1 p.m.
Patient Experience – Best Practices for the New Normal	May 17	12 to 1:30 p.m.
Patient Experience – Best Practices for the New Normal	May 22	2 to 3:30 p.m.
Patient Experience – Best Practices for the New Normal	June 8	9 to 10:30 a.m.

Coding Complex Cases: For physicians, coders, billers and administrative staff.

Session	Date	Time
2023 CPT Coding Updates and Coding Complex Cases	May 4	9 to 10 a.m.
2023 CPT Coding Updates and Coding Complex Cases	May 11	12 to 1 p.m.
2023 CPT Coding Updates and Coding Complex Cases	May 16	2 to 3 p.m.
2023 CPT Coding Updates and Coding Complex Cases	June 7	9 to 10 a.m.
2023 CPT Coding Updates and Coding Complex Cases	June 20	12 to 1 p.m.

Questions?

Contact Ellen Kraft at ekraft@bcbsm.com if you have questions about the sessions. Contact the provider training team at ProviderTraining@bcbsm.com if you have questions about registration or using the provider training website.

Accreditation Statement:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Minnesota Medical Association and Blue Cross Blue Shields of Michigan. The Minnesota Medical Association (MMA) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CME Statement:

The Minnesota Medical Association designates this internet this internet live activity for a maximum of *4 AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

BCN Advantage

BCN Advantage℠ Fee Schedule for Professional Services and some policies on enhanced benefits now available

Providers can now access documents that show:

- What BCN Advantage reimburses for professional services
- What enhanced benefits are available to BCN Advantage members with individual plans

Where to locate these documents

Both the *BCN Advantage Fee Schedule for Professional Services* and the enhanced benefit policies are available on the web. Here's how to find them:

1. Visit bcbsm.com/providers.
2. Click *Resources*.
3. Under the "Key forms and documents" heading, click *View all*.
4. On the **For Providers: Forms and Documents page**, scroll to the "Medicare Advantage" heading and click *See more*.
5. Click one of these:
   - **BCN Advantage Fee Schedule for Professional Services**
   - **BCN Advantage Enhanced Benefit Policies**

Keep reading to find out more about these documents.

About the fee schedule

The *BCN Advantage Fee Schedule for Professional Services* includes rates for enhanced benefits and for carrier-priced codes.

A carrier-priced code is a CPT* or HCPCS code that has a specific description for which CMS has not identified a fee. When there's no fee identified by CMS, BCN Advantage establishes the reimbursement.

When a service has a fee schedule amount listed on the *BCN Advantage Fee Schedule for Professional Services*, it doesn't guarantee that the member has coverage for that service.

The rates are effective for dates of service on or after Jan. 1, 2023. The fee schedule will be updated from time to time.

About the enhanced benefit policies

BCN Advantage provides at least the same level of benefits as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This means that BCN Advantage can offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Currently, there's a policy document available for each enhanced benefit offered with the BCN Advantage individual plans. The documents include some or all of these:

- A description of the benefit that Original Medicare offers along with a description of the enhanced benefit offered by BCN Advantage
- Excluded services
- Information about the conditions that must be met for payment
- Information about reimbursement and member cost-sharing
- Billing instructions

Some of the policy documents include other types of information as well.

In the first quarter of 2024, we're planning to make the enhanced benefit policies for members with BCN Advantage group plans available.

COVID-19 DRG enhancements end with the public health emergency

The federal CARES Act implemented a temporary inpatient diagnosis-related group enhancement for Original Medicare payments. Blue Cross Blue Shield of Michigan and Blue Care Network applied the DRG enhancement to our Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠) for both network and non-network providers.

When the public health emergency ends on May 11, 2023, the DRG enhancement will also end.

The DRG enhancement was a temporary 20% increase in the weighting factor for inpatient DRG payments for Medicare patients diagnosed with COVID-19.

For more information on changes occurring with the end of the public health emergency, see our **Temporary changes due to the COVID-19 pandemic document**. See also the article on the front page of this issue.

Nonclinical, transitional care program available to Medicare Advantage members outside of Michigan

In 2021, we announced that Blue Cross Blue Shield of Michigan and Blue Care Network had contracted with naviHealth, an independent company, to reduce avoidable inpatient readmissions through a nonclinical, transitional care program.

Starting in March 2023, this program was made available to Medicare Plus Blue and BCN Advantage members outside of Michigan when they're admitted to an acute care hospital and are then discharged to their homes.

See the article on **Page 13** for details.

Changes to Carelon's (formerly AIM's) provider portal for medical oncology program

On May 14, 2023, Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) will release enhancements to the provider portal for the medical oncology program. The goal of the enhancements is to make the process of submitting prior authorization requests easier.

See the article on **Page 20** for details.

Requirements changed for some medical benefit drugs for most members

For January through March 2023, we added requirements for medical benefit drugs.

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

Transfer Medicare Advantage members to post-acute care facilities immediately after appeals are approved

As a reminder, the Medicare Plus Blue and BCN Advantage Grievance and Appeals units handle requests to appeal denials of post-acute care services for both prior authorization requests and retroactive authorization requests.

See the article on **Page 29** for details about the process for fast, or expedited, appeals.

Patient Care/ Quality

Reminder: New radiology-focused initiative aims to improve quality of care and member outcomes coming soon

As a reminder, Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with Covera Health to launch a radiology-focused quality improvement program to help us better support radiologists and referring providers in their efforts to improve diagnostic quality, overall care and patient outcomes.

This program will start in the second quarter of 2023 for:

- Commercial members who have coverage through fully insured groups or individual coverage
- All Medicare Advantage members

For details about the program, see page 22 of the **January-February issue** of *BCN Provider News* or in the **January issue** of *The Record*.

Note: We previously stated that this program would start in April 2023.

Covera Health is an independent company that supports Blue Cross Blue Shield of Michigan and Blue Care Network by providing programs to help improve the diagnostic quality, quality of care and member outcomes related to radiology.

Nonclinical, transitional care program available to Medicare Advantage members outside of Michigan

In 2021, we announced that Blue Cross Blue Shield of Michigan and Blue Care Network had contracted with naviHealth, an independent company, to reduce avoidable inpatient readmissions through a nonclinical, transitional care program.

Starting in March 2023, this program is made available to Medicare Plus Blue and BCN Advantage members outside of Michigan when they're admitted to an acute care hospital and are then discharged to their homes.

Since 2021, this program has been available to Medicare Plus Blue and BCN Advantage members who are discharged from inpatient acute care facilities in Michigan directly to their homes or to certain post-acute care facilities. (To view the list of participating post-acute care facilities, see our **Dec. 9 provider alert.**)

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

Patient Care/ Quality

We're updating our ambulatory surgery facility incentive model for CQI participation

In mid-2023, Blue Cross Blue Shield of Michigan and Blue Care Network will make updates to the ambulatory surgery facilities Collaborative Quality Initiatives model. We'll introduce additional incentives for ASFs that participate in more than one CQI, as well as a performance-based incentive.

We introduced these changes to the participating ASFs in March 2023 and plan to roll out a portion of the new incentives in June 2023. Details of these changes will be updated in the ASF CQI Program guide by June 2023.

Background

In late 2020, Blue Cross introduced the first incentive model for ambulatory surgery facilities participating in our CQIs. This incentive, introduced as a 1% facility fee increase, supports ASF's clinical data abstraction and reporting, as well as the development of a quality initiatives infrastructure to support CQI operations and implementation of quality initiatives interventions. Qualifying ASFs participating in either the Michigan Arthroplasty Registry CQI, known as MARCQI, or the Michigan Spine Surgery Improvement Collaborative, known as MSSIC, are eligible to receive this incentive.

Additional information

For more information, refer to our provider manual or reach out to your provider consultant. To access the provider manual through our provider portal:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Provider manuals*.

ASFs that are interested in participating in the CQI program can email CQIprograms@bcbsm.com for additional details.

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

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:

New

- Percutaneous Arteriovenous Fistula (pAVF)
- Digital Health Technologies: Diagnostic Applications
- Digital Health Therapies For Attention Deficit/ Hyperactivity Disorder
- Digital Health Therapies For Substance Use Disorders

Established

- Drug Testing in Pain Management and Substance use Disorder Treatment

Maintenance

- Radiofrequency Ablation of the Renal Sympathetic Nerves as a Treatment for Resistant Or Uncontrolled Hypertension

Covered services

- Amniotic membrane and amniotic fluid
- Cosmetic and Reconstructive Surgery
- Aquablation (Transurethral Waterjet Ablation) of the Prostate
- BMT - Hematopoietic Cell Transplantation for Acute Myeloid Leukemia and Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
- Gender Affirming Services
- Radiofrequency Ablation of Miscellaneous Solid Tumors, Excluding Liver Tumors
- Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders
- Genetic testing-analysis of MGMT promoter methylation in malignant gliomas
- Germline genetic testing for gene variants associated with breast cancer in individuals at moderate and high breast cancer risk (for example, CHEK2, ATM, BARD1)
- Genetic testing for cytochrome P450 polymorphisms
- Pharmacogenomic and metabolite markers for patients treated with thiopurines
- Bone growth stimulation: ultrasound accelerated fracture healing device

Noncovered services

- Adjunct and stand-alone ultrasound for routine breast cancer screening
- Transcutaneous Electrical Nerve Stimulation for the Management of Attention Deficit Hyperactivity Disorder
- Evaluation of biomarkers for Alzheimer's disease

Medical Policy Updates

Changes for the end of the public health emergency

On Jan. 30, 2023, the White House announced that it will end the public health emergency on May 11, 2023.

See the article on **Page 1** for details.

Addressing co-morbid medical and behavioral health issues

The Blue Cross Blue Shield Physician Group Incentive Program offers training, support, and incentives to eligible practices to help implement and deliver Collaborative Care, a model which links medical and behavioral health service in order to deliver optimal care and outcomes. While historically this model has mainly been used to treat depression and anxiety, patients with more severe or complex mental health issues, who are relatively stabilized, may also be good candidates.

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

Behavioral Health

Addressing co-morbid medical and behavioral health issues

According to the American Academy of Family Physicians, up to 80% of people with some form of behavioral health issue get their care through their primary care physician, and many prefer this over treatment from a specialized provider.[1] It's also estimated that roughly one third of prescriptions for severe and persistent mental illness (i.e., schizophrenia, bipolar disorder, major depressive disorder) are from the primary care setting.[2]

Not only are severe and persistent mental illnesses complex in and of themselves, but comorbid issues such as increased risk of alcohol and drug use, smoking, poor diet, and the increase in co-morbidity of medical issues such as metabolic syndrome, elevated A1c or diabetes presented by certain types of medications[3] require their own monitoring and care to help members live longer, healthier lives.

Given the complexities of managing major behavioral health and medical conditions, the question is raised: How best to help patients manage both their medical and behavioral health issues, while at the same time providing the best care possible? A solution to this is presented through the Blue Cross Blue Shield Physician Group Incentive Program, or PGIP.

PGIP offers training, support, and incentives to eligible practices to help implement and deliver Collaborative Care, a model which links medical and behavioral health service in order to deliver optimal care and outcomes. While historically this model has mainly been used to treat depression and anxiety, patients with more severe or complex mental health issues, who are relatively stabilized, may also be good candidates.

For example, the Collaborative Care Model (CoCM) will link primary care (or OB/GYN) practitioners with a behavioral health care manager, who will check in with the patient regularly to assess progress toward the treatment goals using validated depression and anxiety scales, provide motivational interviewing and brief interventions to make sure that their comprehensive needs are being met. The team also includes a consulting psychiatrist who reviews the patient case load with the behavioral health care manager regularly to make treatment recommendations. Results of screenings such as those for A1c and LDL levels for members taking antipsychotic medications are available to everyone on the care team.

The primary care physician remains in charge of patient care, but with input and assistance from the behavioral health care manager and the consulting psychiatrist.

The CoCM is also increasingly being used to help patients manage severe mental illnesses such as schizophrenia and bipolar disorder along with their co-morbid medical issues. Training and on-going support to primary care settings can help to manage these serious illnesses while at the same time overcoming the shortage of specialist behavioral health providers.

Our Physician Group Incentive Program offers a CoCM Designation program, training, support and incentives to eligible practices to help them implement and deliver Collaborative Care.[4] This training is provided not only to physicians but also to office and support staff in order to ensure proper service delivery. Not only does this model improve current care for members, but it also shows significant reductions in inpatient and emergency care along with reduced hospital readmissions.[5]

Any practitioners who are interested in participating in this initiative should reach out to their physician organization and also watch for additional articles in provider publications; information on billing tips related to this model can be also found through past issues of *The Record*.[6] In addition, providers who participate in Collaborative Care can now be identified through the **bcbsm.com/find-a-doctor** search, making providers involved in Collaborative Care more widely available to members seeking integrated care.

For more information on PGIP, visit the **Physician Group Incentive Program** section of **valuepartnerships.com**.

1. Kieu, A. (2021, April 30). ***Now more than ever, mental health care needs family medicine***. Family Practice Management
2. Jetty, A., Petterson, S., Westfall, J. M., & Jabbarpour, Y. (2021). ***Assessing primary care contributions to behavioral health: A cross-sectional study using Medical Expenditure Panel Survey***. Journal of Primary Care & Community Health
3. WebMD. (n.d.). ***Schizophrenia and diabetes***
4. **The Record - *Blue Cross offers incentives and training to expand use of Collaborative Care Model***
5. **The Record - *Announcing our PCMH and Collaborative Care Designations***
6. **The Record - *Review These Important Collaborative Care Billing Tips***

Blue Cross works with Quartet to connect behavioral health providers with members, starting July 1, 2023

Action item

Learn how we're working with Quartet to help members access behavioral health care and how you can join the Quartet online platform.

Blue Cross Blue Shield of Michigan has contracted with Quartet, an independent company that offers an online care navigation solution. The company connects behavioral health providers with new patients through an online platform at no cost to the provider or patient.

We know that some of our members struggle to find the behavioral health care they need. Our relationship with Quartet is designed to help our members who are having difficulty obtaining timely care from a behavioral health specialist in their area. Quartet helps members access outpatient behavioral health services with an appropriate provider more quickly.

Starting July 1, 2023, Quartet will begin referring members seeking outpatient treatment to behavioral health providers registered on Quartet's platform, based on their clinical specialty and their availability.

Quartet's services will be available to the following adult members (18 years of age or older) who reside in Michigan:

- Fully insured Blue Cross commercial members
- Fully insured Blue Care Network commercial members
- All BCN Advantage℠ members
- Select Medicare Plus Blue℠ members

Through Quartet, a behavioral health provider can receive referrals, accept new patients, track the patient's progress and access clinical assessments and other resources.

Joining the Quartet online platform

Beginning April 2023, Quartet will begin reaching out to Blue Cross and BCN participating behavioral health providers to assist them with joining the Quartet online platform. Participation is voluntary. We encourage our behavioral health providers to join and hope they will see the value in this tool for both practitioners and patients.

Here's how Quartet works

1. Quartet works with the provider to create a provider profile and add the provider to the platform.
2. Quartet matches members seeking outpatient behavioral health care to a provider based on their geographic location, treatment needs and preferences. Quartet can refer members to both in-person and virtual care.
3. Quartet sends a referral to the selected provider through the platform for a specific member.
4. The provider reviews and accepts or declines the referral.
5. When the provider accepts the referral, the provider contacts the member to schedule an appointment.

Please visit **quartethealth.com/mental-health-providers** for more information, to schedule a demo or if you would like to sign up.

Quartet is an independent company contracted by Blue Cross Blue Shield of Michigan to connect Blue Cross and BCN members seeking outpatient behavioral health services with the appropriate behavioral health providers.

Behavioral health providers and support staff urged to attend Blue Cross Personalized Medicine℠ webinar

As announced on **page 8 of the March-April issue**, Blue Care Network is hosting a webinar on the new precision medicine pharmacogenomics, or PGx, program called Blue Cross Personalized Medicine℠.

All BCN behavioral health providers and their support staff are invited to attend, but the webinar will be most beneficial for prescribers as it will discuss medication optimization.

When is the webinar?

This free, one-hour webinar will be held on Wednesday, May 24 at 8 a.m. Eastern Time.

What will I learn?

By attending this webinar, you'll learn:

- How the RightMed test uses the patient's DNA to provide insight into how the patient may respond to certain medications based on their unique genetic makeup
- How you, as a prescriber, can use this knowledge to achieve better patient outcomes through medication optimization
- The process from patient invitation through testing completion and the report you'll receive to help inform your medication decisions

You'll also hear specific behavioral health PGx case study success stories.

How can I register?

Register for the webinar through our provider training website.

- Already registered for the provider training website?
  1. **Log in**.
  2. On the main page, click on the webinar you wish to attend under Upcoming Events on the right side of the page.
- Not yet registered for the provider training website?
  1. **Complete the registration process**. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan and Blue Care Network for other needs. This will become your login ID.
  2. **Log in**.
  3. On the main page, click on the webinar you wish to attend under Upcoming Events on the right side of the page.

Even if you attended the PGx behavioral health webinar in 2022 or have patients involved with the program, please consider attending to learn more and ask questions.

Quality Corner

The Michigan Quality Improvement Consortium (MQIC) publishes clinical practice guidelines for various medical and behavioral health disorders, which are updated every two years. The MQIC committee is comprised of medical directors from a wide variety of insurers and professional organizations across the state of Michigan and is devoted to publishing evidence-based guidelines in order 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 is also a guideline on prescribing opioid medications (excluding palliative and end-of-life care. The MQIC Guidelines are intended for behavioral health and primary care professionals in order 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:
    http://mqic.org/pdf/mqic_diagnosis_of_adhd_for_children_and_adolescents_cpg.pdf
  - Treatment guidelines:
    http://mqic.org/pdf/mqic_treatment_of_adhd_for_children_and_adolescents_cpg.pdf
- Depression
  - Primary Care Diagnosis guidelines:
    http://www.mqic.org/pdf/mqic_primary_care_diagnosis_and_management_of_adults_with_depression_FINAL%202022.pdf
  - Treatment Guidance update alert:
    http://www.mqic.org/pdf/mqic_2022_primary_care_diagnosis_and_management_of_adults_with_depression_update_alert.pdf
- Diabetes
  - Diabetes Mellitus Management guidelines:
    http://www.mqic.org/pdf/mqic2022managementofdiabetesmellitusALERT.pdf
  - Management of Diabetes Mellitus:
    http://www.mqic.org/pdf/managementofdiabetesmellitusFINAL2022.pdf
- Opioid Prescribing
  - Prescribing Guideline update alert:
    http://mqic.org/pdf/mqic2022OpioidPrescribinginAdultsExcludingPalliativeandEndofLifeCareALERT.pdf
  - Opioid Prescribing in Adults (Excluding Palliative and End-of-Life Care) guideline:
    http://mqic.org/pdf/opioidprescribinginadultsexcludingpalliativeandendoflifecareFINAL2022.pdf
- Substance Use
  - Screening, Diagnosis, and Referral for Substance Use Disorders guideline:
    http://www.mqic.org/pdf/mqic_screening_diagnosis_and_referral_for_substance_use_disorders.pdf

To join the MQIC mailing list to be notified of any updates, use this link: **http://mqic.org/guidelines.htm#signup-now**.

Pharmacy News

Changes to Carelon's (formerly AIM's) provider portal for medical oncology program

On May 14, 2023, Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) will release enhancements to the provider portal for the medical oncology program. The goal of the enhancements is to make the process of submitting prior authorization requests easier.

Starting May 14, the look and functionality of the clinical intake screens will change. Among other changes, you'll notice:

- An improved look and feel in the case entry screens
- That biomarker questions are no longer presented for clinical scenarios to which the questions don't apply
- That changes to the drug dosing screens make it easier to enter cycle ranges and dates of administration

Register for a webinar to learn more

To learn more about the changes you'll see when submitting prior authorization requests for medical oncology drugs, register for one of the following webinars, which will be hosted by Carelon. (All times are Eastern time.)

Day	Date	Time	Registration link
Tue.	May 16, 2023	1-2 p.m.	**Register**
Thur.	Aug. 10, 2023	3-4 p.m.	**Register**
Tue.	Nov. 14, 2023	3-4 p.m.	**Register**

Additional information

If you have questions about Carelon's provider portal or about submitting prior authorization requests for medical oncology drugs, email Carelon at MedicalOncologySolution@aimspecialtyhealth.com.

For more information about the medical oncology program, see the following pages of our **ereferrals.bcbsm.com** website:

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

Carelon Medical Benefits Management (formerly 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.

BCN Provider News
Feedback

Requirements changed for some medical benefit drugs for most members

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 comprehensive lists of requirements for our members.

For January through March 2023, we added requirements for medical benefit drugs.

For Blue Cross commercial and BCN commercial members

We added prior authorization requirements, site-of-care requirements or both as follows:

HCPCS code	Brand name	Generic name	Requirement	
			Prior authorization	Site of care
J3590*	Adstiladrin®	nadofaragene firadenovec-vncg	✓	
J3590*	Briumvi™	ublituximab-xiiy	✓	
J3590*	Fylnetra®	pegfilgrastim-pbbk	✓	
J3590*	Lamzede	velmanase alfa-tycv	✓	
J3590*	Leqembi™	lecanemab	✓	
J3590*	Rolvedon™	eflapegrastim-xnst	✓	
J3590*	Rebyota™	fecal microbiota, live-jslm	✓	
J3590*	Spevigo®	spesolimab-sbzo		✓
J3590*	Stimufend®	pegfilgrastim-fpgk	✓	
J3590*	Syfovre™	pegcetacoplan	✓	
J3590*	Vegzelma®	bevacizumab-adcd	✓	
J3590*	Xenpozyme™	olipudase alfa		✓

*May be assigned a unique code in the future.

Please see Requirements changed continued on Page 22

Pharmacy News

For Medicare Plus Blue℠ and BCN Advantage℠ members

We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name	For dates of service on or after
J3590*	Leqembi™	lecanemab-irmb	01/13/2023
J3590*	Rolvedon™	eflapegrastim-xnst	03/01/2023
J3590*	Stimufend®	pegfilgrastim-fpgk	03/01/2023
J3590*	Vegzelma®	bevacizumab-adcd	03/01/2023
J3590*	Rebyota™	fecal microbiota, live-jslm	03/01/2023

*May be assigned a unique code in the future.

Drug lists

For additional details, see the following drug lists:

- For commercial members: **Blue Cross and BCN utilization management medical drug list**
- For Medicare Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**.

These lists are also available on the following pages of the **ereferrals.bcbsm.com** website:

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

Additional information about these requirements

We communicated these changes previously through provider alerts. Those alerts contain additional details.

You can view the provider alerts on ereferrals.bcbsm.com and on our Provider Resources site, which is accessible through our provider portal (**availity.com**).

Additional information for Blue Cross commercial groups

For Blue Cross commercial groups, authorization requirements apply only to groups that 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.

Reminder

An authorization approval isn't a guarantee of payment. Health care providers 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.

Briumvi™ to have a site-of-care requirement for most commercial members starting July 1

For dates of service on or after July 1, 2023, 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:

- Briumvi (ublituximab-xiiy), HCPCS code J3590

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for this drug. If the request meets clinical criteria for the drug and is for one of the following sites of care, it 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 Briumvi in an outpatient hospital setting.

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

Members who start courses of treatment with Briumvi before July 1, 2023, 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 requirement outlined above will apply.

Some Blue Cross commercial groups not subject to these requirements

For Blue Cross commercial groups, the prior authorization and site-of-care requirements apply only to groups that 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 July 1, 2023.

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.

Pharmacy News

Starting July 1, we'll change how we pay for certain drugs that must be administered by a health care provider

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 July 1, Blue Cross Blue Shield of Michigan and Blue Care Network will change how we pay for certain drugs.

We'll no longer pay for these drugs with the member's prescription drug benefit. These drugs should only be administered by a health care provider, and therefore we'll pay for them with the member's medical benefit. We'll work with the member's doctor to switch the medication to their medical benefit. Our prescription drug benefits only pay for drugs that can be self-administered by the patient, per FDA-approved prescription labeling.

These changes affect all pharmacy drug lists where the drug is currently covered by the prescription drug benefit.

Drugs paid for only by medical benefits starting July 1, 2023		
Generic name	**Brand name**	**Common use**
lanreotide	lanreotide (brand)	Acromegaly, carcinoid syndrome, gastroenteropancreatic neuroendocrine tumors
	Somatuline® Depot	
octreotide	Sandostatin® LAR®	
pasireotide	Signifor® LAR	Acromegaly, Cushing's disease

We'll send letters to affected groups, members and their health care providers. We'll advise them to talk with their doctor about continuing to receive their treatment, which should be billed to their medical benefits.

AIM changed its name to Carelon

In March 2023, AIM Specialty Health® changed its name to Carelon Medical Benefits Management. The name change does not affect how they work with providers.

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

More information about changes to the inpatient readmission review guidelines starting June 1

In the **March-April 2023 issue** of *BCN Provider News*, we announced that starting June 1, 2023, BCN will change the guidelines it uses to review inpatient readmissions of BCN commercial and BCN Advantage members for billing purposes.

The primary change is that BCN will review admissions for BCN commercial and BCN Advantage members readmitted within 30 days of discharge. Currently, BCN reviews admissions for members readmitted within 14 days of discharge.

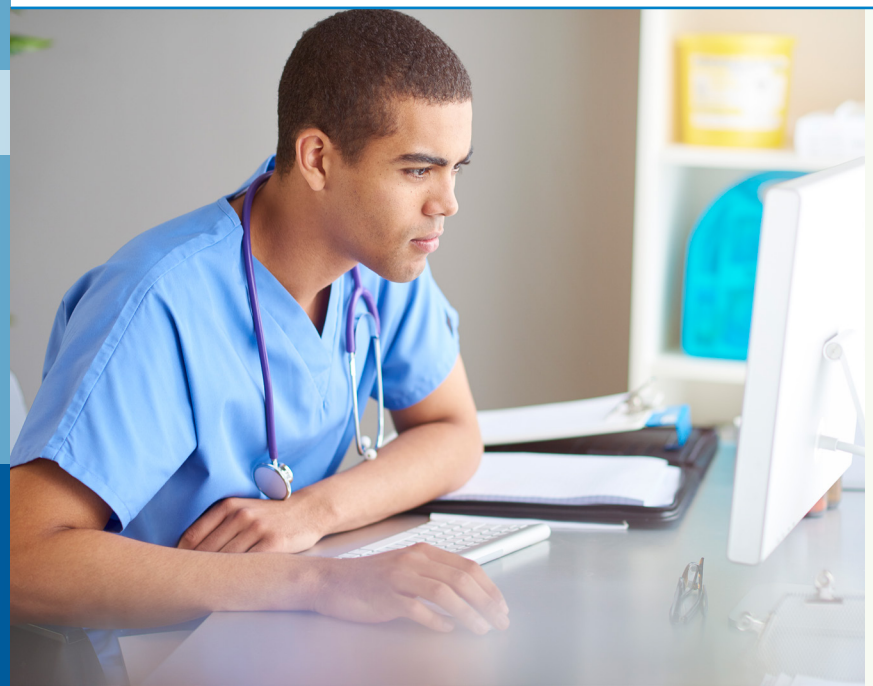
The new bundling guidelines will be applied to readmissions that occur on or after June 1, 2023. We'll review to determine whether two separately billed admissions should be bundled and paid as one admission.

If we determine that an admission that was already paid should have been bundled, we will retrospectively bundle the admission with the readmission and reimburse only one DRG payment.

These guidelines apply to facilities that are reimbursed by diagnosis-related groups, or DRGs. In some instances, BCN combines the two admissions into one for purposes of the DRG reimbursement.

You can access the current **Guidelines for Bundling Admissions** by following the steps below. We'll update that document before June 1 to reflect any changes.

1. Visit **ereferrals.bcbsm.com**.
2. Click *BCN*.
3. Click *Authorization Requirements & Criteria*.
4. Click *Guidelines for Bundling Admissions* under the "Referral and authorization information" heading and the "Acute inpatient care" subheading.



*BCN Advantage*SM Fee Schedule for Professional Services and some policies on enhanced benefits now available

Providers can now access documents that show:

- What BCN Advantage reimburses for professional services
- What enhanced benefits are available to BCN Advantage members with individual plans

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

Billing Bulletin

COVID-19 DRG enhancements end with the public health emergency

The federal CARES Act implemented a temporary inpatient diagnosis-related group enhancement for Original Medicare payments. Blue Cross Blue Shield of Michigan and Blue Care Network applied the DRG enhancement to our Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠) for both network and non-network providers.

When the public health emergency ends on May 11, 2023, the DRG enhancement will also end.

See the article on **Page 12** 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:

- Submitting Pathology Reports with Clinical Editing Appeal
- Therapeutic Radiology Simulation-Excess of Units Denial

Clinical Editing Billing Tips

Referral Roundup

AIM changed its name to Carelon

In March 2023, AIM Specialty Health® changed its name to Carelon Medical Benefits Management.

The name change doesn't affect how they work with providers. For example:

- Carelon still manages authorizations for the services they managed before the name change.
- The company's provider portal web address didn't change and providers can access it:
  - Through our provider portal (**availity.com**)
  - Directly at **providerportal.com**
- The call center numbers will remain the same:
  - Blue Care Network: 1-844-377-1278
  - Blue Cross Blue Shield of Michigan: 1-800-728-8008

  A recorded message will advise callers of the name change to Carelon Medical Benefits Management.
- Visitors to the current AIM **Clinical Guidelines** site and **corporate webpage** will automatically be redirected to a Carelon web address.
- Clinical decision letters and other communications will transition to display the Carelon Medical Benefits Management name and logo.

The important thing to know is that this is a change only to the AIM Specialty Health name. There will be no changes to the way providers submit prior authorization requests.

Carelon Medical Benefits Management (formerly known as 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.

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

Starting June 1, submit prior authorization requests for human organ transplants through e-referral and not by fax

Beginning June 1, 2023, we'll require providers located in Michigan to submit prior authorization requests for human organ transplant procedures through the e-referral system and not by fax.

This applies to requests for Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial and BCN Advantage members having bone marrow and specified solid organ transplant procedures.

This doesn't include kidney transplant procedures except for Blue Cross and Blue Shield Federal Employee Program® members, for whom kidney transplant procedures require prior authorization.

Currently, most providers are faxing these requests to us.

This change doesn't apply to Medicare Plus Blue℠ members.

Hospital transplant financial coordinators must contact their Availity® administrator

To prepare for this change, hospital transplant financial coordinators must contact their Availity administrator so the administrator can:

- Give the coordinator access to our provider portal (**availity.com**)
- Set up the e-referral tool within Availity for the coordinator

Important: We'll contact each coordinator by email to help them determine who their Availity administrator is.

In addition, we'll schedule webinars in May so the coordinators can learn how to use the e-referral system. We'll notify the coordinators directly about registering for the webinars.

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

Determining prior authorization requirements for patients with non-Michigan Blue plans

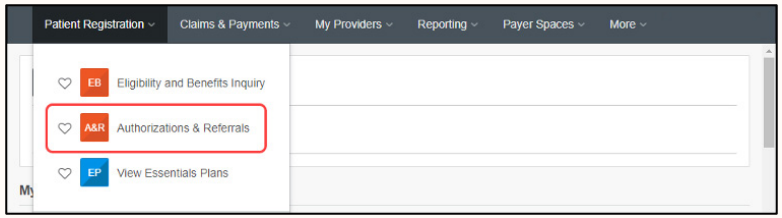
Michigan providers can find information about prior authorization requirements for patients with non-Michigan Blue plans as follows:

- Specific information may be available through Availity®. See the *Specific information* section below for details.
- General information is available through our Medical Policy & Pre-Cert/Pre-Auth Router. See the *General information* section later in this article for details.

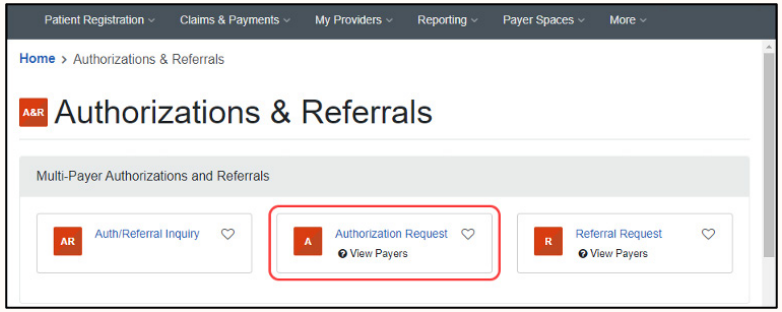
Specific information

Specific information about prior authorization requirements may be available through Availity.

1. Log in to our provider portal (**availity.com**).
2. Click *Patient Registration* and then click *Authorizations & Referrals*.



3. Click *Authorization Request*.



4. In the Select a Payer screen, make these selections:

Field	Selection
Organization	Select the appropriate organization.
Payer	Select *BCBS Michigan and Blue Care Network*.
Request Type	Select the appropriate type of request.

5. Click *Next*.
6. In the *Select a Patient* field, choose any patient.
7. In the *Member ID* field, enter the subscriber ID from the non-Michigan member's ID card. Be sure to include the three-character alpha prefix.
8. Complete the fields in the Requesting Provider section and click *Next*.
9. Based on what you see on the screen, complete the rest of the steps.

What you see on screen	What to do
"Important: You have been routed from BCBSM Michigan and Blue Care Network to BCBSXX to conduct pre-service review for a BCBSXX member."	1. Click the *Inpatient Authorization* or *Outpatient Authorization* link. 2. The Authorizations page opens to the Requesting Provider section. 3. Scroll up to the Patient Information section at the top of the screen. 4. Enter the non-Michigan member's member ID, relationship to the subscriber, first and last name and date of birth. 5. Enter the appropriate information in all required fields.
A Blue Cross Blue Shield Association disclaimer that states: "You are about to be redirected to a third-party site, which may require a separate log-in…"	1. Click *Submit*. 2. Follow the instructions in the screen that opens.

Please see Determining prior continued on Page 29

General information

For general information about services that require authorization, go to our Medical Policy & Pre-Cert/Pre-Auth Router. To access the router:

1. Go to **bcbsm.com/providers**.
2. Click *Resources*.
3. Click the **out-of-area router** link.
4. Click the *General pre-certification/pre-authorization information* option.
5. Enter the three-character alpha prefix from the non-Michigan member's subscriber ID in the Prefix field.
6. Click *Go*.

Additional information

You can also find this information in the **Determining prior authorization requirements for a member** document. That document also explains how:

- Michigan providers can look up requirements for patients who have coverage through Blue Cross of Blue Shield of Michigan or Blue Care Network plans.
- Non-Michigan providers can look up requirements for patients who have coverage through Blue Cross of Blue Shield of Michigan or Blue Care Network plans.

You can access this document by clicking the *Determine prior authorization requirements for members* tile on the left side of any page of our **ereferrals.bcbsm.com** website.

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

Transfer Medicare Advantage members to post-acute care facilities immediately after appeals are approved

As a reminder, the Medicare Plus Blue and BCN Advantage Grievance and Appeals units handle requests to appeal denials of post-acute care services for both prior authorization requests and retroactive authorization requests.

Here's what you need to know about the process for fast, or expedited, appeals.

Transfer the patient as soon as you receive approval

When you submit a fast, or expedited, appeal to Blue Cross Blue Shield of Michigan or Blue Care Network, we have 72 hours to approve or deny the appeal. Within those 72 hours, we'll send a fax to inform you of our determination.

Once you receive a fax stating that an appeal has been approved, you can immediately transfer the member to a post-acute care facility.

Although naviHealth will provide an authorization number later, don't wait for that number to transfer the patient. The fax you received serves as proof of the approval.

Post-acute care providers should accept the transfer based on the faxed notification stating that we approved the appeal.

If you'd like a status update on an appeal request, call us at:

- For Medicare Plus Blue members: 1-866-309-1719
- For BCN Advantage members:
  - Facility providers: 1-800-249-5103
  - Professional providers: 1-800-344-8525

How to submit an appeal to get the fastest response

For the fastest response to your appeal request:

1. Include all current and relevant medical documentation to ensure the appeal can be processed in a timely manner.
2. Fax it to the fax number listed on the denial letter.

   If you don't have a copy of the denial letter, you can request a copy from naviHealth by calling 1-855-851-0843 or by submitting a request through nH Access.

Please see Transfer Medicare Advantage continued on Page 30

3. On the fax cover sheet, be sure to indicate that you're requesting a fast, or expedited, appeal.

For your convenience, the fax numbers for submitting appeals are:

- For Medicare Plus Blue members: Fax to 1-877-348-2251.
- For BCN Advantage members: Fax to 1-866-522-7345.

Additional information

For additional information about post-acute care services for Medicare Advantage members, see the **Post-acute care services: Frequently asked questions for providers** document.

naviHealth is an independent company that provides select care management services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Prior authorization changes coming in June

Michigan's **prior authorization law requirements** go into effect on June 1, 2023. These requirements apply to insurers and providers in Michigan for members who have commercial coverage.

These requirements aim to give members and health care providers a clearer understanding of the services that require prior authorization and of the prior authorization criteria for medical and pharmacy benefits.

The areas that will be affected are:

Area	Requirements of the law
Services and benefits that require prior authorization and medical necessity criteria	The following must be posted to a publicly available website: • A list of all services and benefits that require prior authorization • Medical necessity criteria for all benefits This information must be posted as follows: • For medical services: 60 days in advance of changes. • For pharmacy services: 45 days in advance of changes, with some exceptions for patient safety Note: While this information is currently available to Blue Cross Blue Shield of Michigan and Blue Care Network members and providers, we're working to consolidate it, make it more easily accessible and present it in more easily understandable language. The law also requires insurers to modify prior authorization requirements based on provider performance. We already have several gold carding programs in place that meet this requirement.
Turnaround times	Turnaround times for prior authorization requests will change. • **For standard prior authorization requests** We must make determinations on requests or ask for additional information as follows: - Within 9 days of submission, for requests submitted on or after June 1, 2023 - Within 7 days of submission, for requests submitted on or after June 1, 2024

Please see Prior authorization continued on Page 31

Turnaround times (cont'd.)	• **For urgent prior authorization requests*** We must make determinations on requests or ask for additional information within 72 hours of submission for requests submitted on or after June 1, 2023. **Important:** If we ask for additional information, providers should submit it as soon as possible. Once the provider submits the additional information, the turnaround time noted above will reset. For example, we must make a determination within 72 hours of receiving additional information for an urgent request. Approved prior authorization requests will be valid for a minimum of 60 days or for the length of time that's clinically appropriate, whichever is longer. As is true now, providers and members will be able to appeal prior authorization requests that aren't approved.
Electronic prior authorizations	Insurers must provide an online method through which providers can submit prior authorization requests for all services, including prescription drugs. Online submission methods include our e-referral tool, online tools provided by vendors who manage certain authorizations on our behalf, and electronic prior authorization (or ePA) tools. Notes: • We'll continue to provide alternate submission methods (fax or phone) for times when providers are unable to submit requests online due to power outages, internet outages and so on. • For members who have Blue Cross commercial coverage through MESSA, providers must submit prior authorization requests to MESSA for certain services. Starting June 1, there will be a new process for providers to submit these requests online for MESSA members. Look for additional information in upcoming provider alerts and issues of *The Record*.
Reporting	Insurers must submit reports about prior authorizations annually to the Michigan Department of Insurance and Financial Services, or DIFS, on June 1 of each year, beginning in 2023. Reporting will include the number of prior authorization requests that weren't submitted to us using an online submission method.
Member appeals	We'll communicate details before June 1.

These requirements also apply to the third-party vendors with which Blue Cross and BCN have contracted to manage prior authorizations for certain services. We're working with these vendors to ensure compliance with the law.

As we make changes, we'll publish provider alerts and newsletter articles with additional information. For example, we announced in the February issue of *The Record* that **voluntary prior authorization ends on May 1**.

Be sure to check member eligibility and benefits through our provider portal (**availity.com**) or Provider Inquiry prior to performing services.

*A request for medical care or services is considered urgent when the time frame for making determinations for routine or non-life-threatening care would do one of the following: (1) seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a layperson's judgment, (2) seriously jeopardize the life, health or safety of others, due to the member's psychological state or (3) subject the member to adverse health consequences without the care or treatment that is the subject of the request, in the opinion of a practitioner who has knowledge of the member's medical or behavioral condition.

Starting June 1, requests for commercial LTACH admissions and extensions must be submitted through e-referral and not by fax

Beginning June 1, 2023, we'll require long-term acute care hospitals, or LTACHs, 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 Blue Shield of Michigan and Blue Care Network commercial members for:

- Initial admissions
- Additional days (extensions)

Currently, many LTACH providers in Michigan use the Blue Cross and BCN *LTACH assessment form* to fax their prior authorization requests.

For Michigan providers

Starting June 1, 2023:

- We'll stop accepting faxed requests as a general practice.
- We'll accept faxes **only** for urgent requests and **only** 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**.

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

For non-Michigan providers

LTACH providers outside of Michigan can either:

- Continue to submit their requests by fax.
- Submit the request through the e-referral system.

  For additional information, refer to the document titled **Determining prior authorization requirements for members** and look for the information for non-Michigan providers. Prior authorization **is** required for LTACH stays and the steps in that document will show you how to access the e-referral system.

We'll offer training

In May, we'll schedule webinars for LTACH 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. Click *Payer Spaces* on the menu bar and then 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.

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

naviHealth is an independent company that provides select care management services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Referral Roundup

Reminder: New radiology-focused initiative aims to improve quality of care and member outcomes coming soon

As a reminder, Blue Cross Blue Shield of Michigan and Blue Care Network have contracted with Covera Health to launch a radiology-focused quality improvement program.

See the article on **Page 13** for details.

Requirements changed for some medical benefit drugs for most members

For January through March 2023, we added requirements for medical benefit drugs.

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

Briumvi™ to have a site-of-care requirement for most commercial members starting July 1

For dates of service on or after July 1, 2023, 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:

Briumvi (ublituximab-xiiy), HCPCS code J3590

See the article on **Page 23** for details.

More information about changes to the inpatient readmission review guidelines starting June 1

Starting June 1, 2023, BCN will change the guidelines it uses to review inpatient readmissions of BCN commercial and BCN Advantage members for billing purposes. The primary change is that BCN will review admissions for BCN commercial and BCN Advantage members readmitted within 30 days of discharge.

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

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Some pre-COVID-19 utilization management requirements to resume July 1

With the end of the COVID-19 public health emergency, or PHE, Blue Cross Blue Shield of Michigan and Blue Care Network will reinstate utilization management requirements that were in effect before the PHE.

Topic	During the PHE	Change
For BCN Advantage members, services from providers who are not associated with the member's plan.	Prior authorization requests were approved without clinical review.	Clinical review will be required for dates of service on or after July 1, 2023.
For all members, acute medical inpatient admissions related to COVID-19, flu, pneumonia or respiratory syncytial virus (RSV).	Prior authorization requests were approved without clinical review.	Clinical review will be required for admissions on or after July 1, 2023.
Appeal of prior authorization determinations made by Blue Cross or BCN for any service.	The time frames for submitting appeals were waived.	The normal time frames for submitting appeals will be reinstituted starting July 1, 2023. Refer to the denial letters for the time frames.

Feedback | Subscribe

Inside this issue…

BCN offers incentive for PCPs who provide in-person care for BCN Virtual Primary Care patients

Starting with dates of service May 1, 2023, Blue Care Network is offering an incentive for BCN primary care providers who agree to see an adult member (age 18 and older) in their office who is enrolled in one of these two BCN commercial health plans, and for whom the BCN network PCP has received a referral:

- BCN Virtual Primary Care℠ HMO
- Blue Cross® Preferred HMO Virtual Primary Care

Most of the care received by the members enrolled in these products is managed virtually by our vendor, Doctor on Demand by Included Health®. On occasion, one of these members may need to be referred to a contracted PCP for an in-person visit. *If a BCN PCP accepts a referral for one of these members and conducts the requested service, the PCP will receive an additional 20% reimbursement in addition to the PCP's contracted rate.*

Receiving a referral

Here's how a referral from Doctor on Demand to a BCN network PCP works:

1. The Doctor on Demand referral coordinator calls a BCN network PCP local to the member to ask if the PCP will accept a member for a referral to evaluate a specific need.
2. Once the referral is accepted, Doctor on Demand will input the referral into BCN's e-referral system and fax to the network PCP any pertinent information, such as past labs or imaging.
3. The network PCP can view the referral in BCN's e-referral system by searching for the patient using the Patient ID (subscriber number on the ID card). In the list of cases for that patient, look for a case with the Referring Provider or PCP listed as "Roy, Vibin." Referrals from Doctor on Demand will always list the Referring Provider and PCP as "Roy, Vibin."
4. If the network PCP needs to speak with the member's Doctor on Demand PCP, the network PCP can call 1-855-431-5552. Have the member's information available to connect to that member's virtual PCP or care team.

More information

Here's where you can find more information on BCN's Virtual Primary Care health plan:

- **Learn more about our new virtual primary care plan**, Jan.-Feb. 2023 issue of *BCN Provider News*, page 6
- Virtual Primary Care frequently asked questions for providers is available in the provider portal. Here's how to find it:
  1. Log in to our provider portal (availity.com).
  2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
  3. Click the *Resources* tab.
  4. Click *Secure Provider Resources (Blue Cross and BCN)*.
  5. Click *Products* on the menu bar and click *BCN*.
  6. Scroll down to the Virtual Primary Care section.

Please see BCN offers incentive for PCPs continued on Page 3

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Need help?

Should you have any questions regarding this notification, here's who to contact:

- For primary care providers associated with a medical care group:

  Contact the provider consultant assigned to your medical care group. You can find your consultant on our **physician organization consultants** list.
- For other providers in the East, Mid or Southeast regions:

  Send an email to petcontactus@bcbsm.com and include your name, phone number, National Provider Identifier, provider type (for example, primary care provider, cardiologist), and your issue or question.
- For other providers in the Upper Peninsula or West regions:

  Contact your provider consultant directly by selecting your location using our **Upper Peninsula** or our **West region** contact list.

If you don't know which region you're in, **view our map**.

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

We're offering educational webinars that will provide updated information on documentation and coding of common challenging diagnoses. These live, lunchtime sessions will also include an opportunity to ask any questions that you may have.

Here's our current schedule and the tentative topics for the webinars. These 30-minute sessions start at noon Eastern time. Log in to the provider training website and register for the session that best works with your schedule.

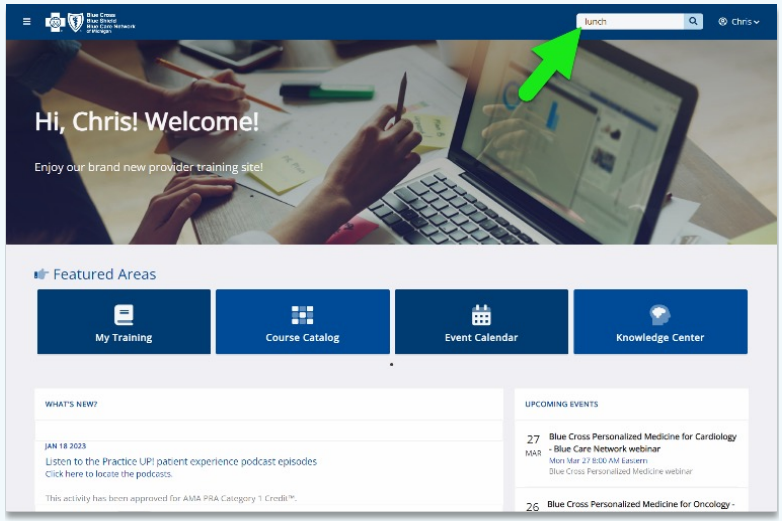
If you haven't already registered for the provider training website, follow these steps:

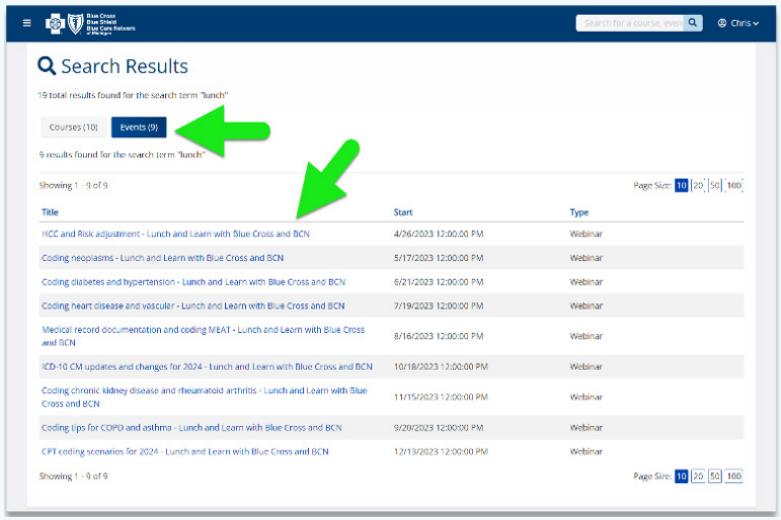
1. **Click here to register**.
2. Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan for other needs. This will become your login ID.

Session Date	Topic
June 21	Coding diabetes and hypertension
July 19	Coding heart disease and vascular
Aug. 16	Tips for proper medical record documentation and coding MEAT
Sept 20	Coding tips for COPD and asthma
Oct. 18	ICD-10-CM updates and changes for 2024
Nov. 15	Coding chronic kidney disease and rheumatoid arthritis
Dec.13	CPT coding scenarios; a look at the new CPT codes for 2024

Locating a session

Click here if you are already registered for the provider training website. On the provider training website, look in the *Event Calendar* or use the search feature with the keyword **lunch** to quickly locate all 2023 sessions.





Please see Lunch and learn webinars continued on Page 5

You can listen to the previously recorded sessions too. Check out the following:

Previously recorded	Topic
April 26	HCC and risk adjustment coding scenarios
May 17	Coding Neoplasms

For more information

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions regarding session or website registration, email ProviderTraining@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.

Action item

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

We recently added the following new learning opportunities:

- CMS Star measures overview for 2023

  This course is an overview of HEDIS® quality measures, which are also Medicare Star Ratings measures. Updated for 2023, the course has a new section about the CAHPS® survey, tips for closing gaps, clarifications on quality measure requirements and assistance with coding and documentation.

- HEDIS measures scenarios for 2023

  This course shows you how to close quality gaps using the HEDIS tip sheets. You will learn the tips and tricks through a series of scenarios where you help figure out why the office is seeing gaps in specific measures. The course has been updated for 2023.

Check the dashboard on our provider training site, which is available to enhance the training experience for health care providers and staff, for announcements as we add more courses, including those with CME offerings.

To request access to the training site, 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.

Network Operations

Balance billing by noncontracted ambulance services continues to stress patients

As a reminder, providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers to prevent patients from being balanced billed large amounts from noncontracted ambulance services.

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

Discuss health concerns addressed in Medicare Health Outcomes Survey with your patients

Action item

Check out our **Health Outcomes Survey tip sheet** to learn how you can address care opportunities with your Medicare Advantage patients.

Beginning in July, some of your Blue Cross Blue Shield of Michigan and Blue Care Network patients with Medicare Advantage plans may receive the annual Health Outcomes Survey, or HOS, conducted by Centers for Medicare & Medicaid Services. The survey will ask them about the status of their physical and mental health, and how well they have been advised by their physician on fall prevention, managing urinary incontinence and physical activity.

How you can make a difference

The interactions you have with your patients directly affect the responses on the survey. Some patients may need your encouragement to discuss their concerns during their annual physical. Having discussions and advising them on the topics covered in the HOS improves your patients' quality of life, engagement in their health and experience with your practice.

Here are some suggestions for topics to discuss at annual physicals:

- Review and address any physical or emotional wellness concerns
- Discuss and advise on appropriate exercise
- Develop treatment plans with patients to address incontinence
- Discuss ways to prevent falls and improve balance

How Blue Cross and BCN are supporting you

- Offering members incentives for annual wellness visits
- Sending members emails and letters to encourage them to have these conversations with you
- Providing health care providers with live and on-demand webinars to address incontinence, physical activity and fall prevention (see the "Find out more about HOS" section below for webinar information)
- Providing members with the SilverSneakers® program
- Providing informational resources

Find out more about HOS

Our CMS Star measures course has a module with more detail about the Health Outcomes Survey. Log in to the **provider training website** and search for the course. Use the keyword "HOS."

If you don't already have access to the provider training website, you can easily **create an account**. We recommend you use the same email address you use to communicate with Blue Cross Blue Shield of Michigan when creating the account.

You can also check out our **Health Outcomes Survey tip sheet** for sample survey questions and tips for success.

Changes to maternity support program and new menopause support program

Last year, Blue Cross Blue Shield of Michigan and Blue Care Network announced that we're working with Maven, an independent company, to provide a Family Building and Maternity Support Solution.

We've renamed this solution to the Family Building and Women's Health Support Solution and we're enhancing it as follows.

Maternity program

Starting in July 2023, this program will offer support during the nine months of pregnancy and for one year postpartum for members who have coverage through Blue Cross and BCN commercial self-funded groups that purchase this program.

There's no change for members who have coverage through Blue Cross and BCN commercial fully insured groups or for members who have individual coverage. The program will still end at three months postpartum for these members.

For additional details about this program, see the **November-December 2022 *BCN Provider News***.

Menopause program

In July, we're adding a menopause program that will provide access to expert advice and resources to members who are experiencing physical and mental symptoms related to menopause. 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.

The support that's available through this program includes:

- Early identification of menopausal symptoms and treatment guidance.
- 24/7 virtual access to a coaching care team that specializes in perimenopause, menopause and postmenopause.
- Within the Maven mobile app, guided education and access to communities for connecting with others in the same stage of life.
- One-on-one mental health support throughout the menopausal journey.

Similar to the rest of the programs for which we're working with Maven, the menopause program will include access to:

- A dedicated **care advocate** who can provide personalized, one-on-one support to answer questions, recommend the right types of care for specific needs, and help members find high-quality, in-network providers.
- **Personalized resources**, including clinically approved articles, community forums to engage with others on similar journeys and classes led by clinical professionals.
- **Clinical virtual support** through 24/7 on-demand video appointments that are available within one hour. Members can speak with top-rated coaches* from clinical specialties, including OB-GYNs, mental health specialists and career coaches. Appointments are available in more than 35 languages. A chat option is also available.

*Maven coaches don't replace in-person care or relationships with established care teams and providers. They're additional resources.

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

Balance billing by noncontracted ambulance services continues to stress patients

As a reminder, providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers to prevent patients from being balanced billed large amounts from noncontracted ambulance services.

You can help patients avoid this situation, which affects Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members, by using only contracted ground ambulance services. To determine which ground ambulance services are contracted with or participate with a member's health plan:

1. Go to bcbsm.com.
2. Click ***Find a Doctor***.
3. Click the *Search without logging in* link.
4. If prompted, choose a location.
5. In the upper-right corner of the screen, do one of the following:
   - Click the *I don't know my network* button.
   - Click the *Change your location or plan* link and then click *I don't know my network*.
6. Click the *Find a different plan* button.
7. Select the appropriate plan.
8. Click the *Confirm selection* button.
9. Click *Places by type*.
10. Enter *Land ambulance* or the name of a specific ambulance provider, and press Enter.

The search results include the ground ambulance services that are contracted with or participate with the plan you selected.

See our *Ground Ambulance Services* medical policy for additional information. To view the policy:

1. Go to bcbsm.com/providers.
2. Click *Resources*.
3. Scroll down the page and click the *Search Medical Policies* button.
4. In the **Medical Policy Router Search** page, enter **ground ambulance services** in the Policy/Topic Keyword field and press Enter.
5. Click the *Medical Policy – Ground Ambulance Services* link.

Reminder: Only charge patients their cost share

When you treat a patient with Blue Cross Blue Shield of Michigan or Blue Care Network coverage, including our Medicare Advantage plans, Medicare Plus Blue℠ or BCN Advantage℠, be sure to bill Blue Cross or BCN for covered services and only charge the member the appropriate cost share according to their health plan coverage.

See the article on **Page 20** 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:

Established

- Enteral Nutrition
- Telemonitoring - Remote Patient Monitoring and Remote Therapeutic Monitoring

Mixed

- Low-Level Laser and High-Power Laser Therapy

Investigational, not medically necessary

- Orthopedic Applications of Stem-Cell Therapy (Including Autologous Stem Cells Used with Allografts and Bone Substitutes)

Covered services

- Magnetic Resonance Spectroscopy
- Speech and Language Pathology/Swallowing Rehabilitation
- Treatment of Varicose Veins/Venous Insufficiency
- Somatic Biomarker Testing (Including Liquid Biopsy) for Targeted Treatment and Immunotherapy in Non-Small-Cell Lung Cancer (EGFR, ALK, BRAF, ROS1, RET, MET, KRAS, HER2, PD-L1, TMB)
- Multimarker Serum Testing Related to Ovarian Cancer (e.g., OVA1®, OVERA™, OvaWatch® and ROMA™) testing
- Genetic Testing for Alzheimer's Disease
- Genetic Testing for Rett Syndrome
- Growing Rods for Scoliosis (e.g., MAGEC Spinal Bracing and Distraction System)
- Bariatric Surgery
- Diagnosis of Sleep Disorders
- Medical Management of Obstructive Sleep Apnea Syndrome (Oral Appliances and Novel Therapies)

Medical Policy Updates

It's important to monitor the metabolic effects of psychiatric medications

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

Antipsychotic medications, along with antidepressants and mood stabilizers, have significant weight gain associated with them.

The newer medications are better than the first-generation drugs but still have this side effect. Second-generation antipsychotic medications, such as Zyprexa® and Risperdal, have the most weight gain associated with them. Seroquel, Latuda®, Abilify® and Invega® tend to cause a medium amount of weight gain, while Geodon has the least effect. In fact, some people actually lose weight while on Geodon.

Antidepressants

Antidepressants in the SSRI class and SNRI class also can contribute to weight gain. Wellbutrin, an atypical agent, has the least amount of weight gain associated with it; some people lose weight on it. Depakote and lithium have long been associated with weight gain. This side effect contributes to glucose intolerance and may lead to diabetes if unmonitored.

There is some evidence that metformin prevents the weight gain. Likewise, more recent information suggests semaglutide is an effective agent to assist in the prevention of metabolic syndrome and, ultimately, diabetes. Before prescribing any of these medications, doctors should discuss possible side effects with the patient and the role that diet and exercise can play in treating prediabetes.

Monitoring patients who are on antipsychotics or antidepressants

Monitoring for metabolic syndrome as outlined below is the standard of care when patients start on these medications. The American Diabetes Association suggests monitoring the following:

- Personal history (at baseline and annually)
- Weight (at baseline, 4 weeks, 8 weeks, 12 weeks, quarterly and annually)
- Waist circumference (at baseline, 12 weeks and annually)
- Blood pressure (at baseline, 12 weeks and annually)
- Fasting plasma glucose/A1C (at baseline, 12 weeks and annually)
- Fasting lipid profile (at baseline, 12 weeks and annually)

If significant issues develop while the patient is on any of these medications, changing medications may be the best solution. Or, if the medication (or medication combination) the patient is on is the only one that works, then treating the resulting metabolic issues aggressively may help enhance the patient's quality of life and decrease adverse events in the future.

We encourage you to monitor the key areas outlined above, making them part of your follow-up routine with patients who are on these medications. It's also important to help patients understand the importance of these measures and the role they play in keeping them well.

Submit prior authorization requests for ABA services through e-referral

Beginning June 1, 2023, licensed behavior analysts, or LBAs, in Michigan must submit prior authorization requests for applied behavior analysis, or ABA, services through the e-referral system. This affects LBAs who provide ABA services to BCN commercial members.

Note: Due to Michigan's prior authorization law requirements, all providers must submit prior authorization requests electronically whenever possible. This requirement applies to behavioral health, medical and pharmacy services that require prior authorization. For more information about the requirements of the law, see the provider alert titled **Update: Prior authorization changes coming in June**.

Here's what you need to do

Each LBA needs to complete the following tasks. If you've already completed them, you don't need to do anything. If you haven't completed them, see the information in the right column.

Task		If you haven't completed this task...
1	Get access to Availity® and the e-referral system.	See the *LBAs must have access to Availity and the e-referral system* section of the **April 20 provider alert** for details.
2	Watch the *Authorization Request & Referral Request for BCBSM Providers – Recorded Webinar* through Availity.	It's important that you complete this training because it includes information that won't be covered in the LBA-specific webinar below. For information about accessing recorded training, see the **Availity Essentials user guide**.
3	Attend or watch the webinar titled *e-referral overview webinar for ABA providers*.	Watch the recorded webinar by doing the following: 1. Log in to the **Blue Cross and BCN provider training website**. (If you don't already have a login and password, click *New User? Click here to register* at the bottom of the screen.) 2. In the Search field near the upper-right corner of the screen, enter *ABA* and press *Enter*. 3. Click *e-referral overview webinar for ABA providers* to access the recorded webinar.

Additional information

We announced this change in an **April 20 provider alert**, and we encouraged LBAs to register for a webinar in a **May 3 provider alert**.

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

Behavioral health providers: How to bill prolonged services

In January 2023, we posted a **provider alert** in which we asked behavioral health providers to hold claims for dates of service on or after Jan. 1, 2023, that contain procedure codes *99354 and *99355. These codes were for prolonged services and were terminated as of Jan. 1, 2023.

At that time, we said we were working on identifying active codes that can be billed in place of the terminated codes.

Here's what to do with the claims you've been holding

For prolonged behavioral health services:

- For Blue Cross and BCN commercial members, use HCPCS code G2212 in place of procedure codes *99354 and *99355 for dates of service on or after Jan 1, 2023. The G2212 code can now be billed with procedure codes *90837 and *90847.
- For Medicare Plus Blue and BCN Advantage members, follow the Centers for Medicare & Medicaid Services billing guidelines.

Here's some additional information:

- HCPCS code G2212 is billed in increments of 15 minutes for each unit of prolonged service after the time of the base code is exhausted.
- You can submit claims for dates of service as early as Jan. 1, 2023.

Reminder

The American Medical Association terminated procedure codes *99354 and *99355 as of Jan. 1, 2023.

- Any claims for dates of service on or after Jan. 1, 2023, that contain those codes will be rejected even if the claims contain codes that are payable.
- Claims with dates of service prior to Jan. 1, 2023, can still be billed with procedure codes *99354 and *99355.

We'll use 2023 InterQual® criteria starting Aug. 1

On Aug. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2023 InterQual criteria to make determinations on prior authorization requests for the behavioral health and non-behavioral health services we manage.

See the article on **Page 23** for details.

Reminder: Only charge patients their cost share

When you treat a patient with Blue Cross Blue Shield of Michigan or Blue Care Network coverage, including our Medicare Advantage plans, Medicare Plus Blue℠ or BCN Advantage℠, be sure to bill Blue Cross or BCN for covered services and only charge the member the appropriate cost share according to their health plan coverage.

See the article on **Page 20** for details.

Pharmacy News

Starting August 15, we'll require a prior authorization for some diabetes drugs

Beginning August 15, 2023, providers will need to submit a prior authorization to show the brand-name medications listed below are being used for Type 2 diabetes to continue coverage for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members. Medicare members are excluded from this change.

Brand-name medication	FDA-approved indication	Coverage requirement
Bydureon® Byetta® Mounjaro® Ozempic® Rybelsus® Trulicity® Victoza®	Type 2 diabetes	Coverage will require the following: 1. Being used for the treatment of Type 2 diabetes OR 2. Trial of one generic or preferred medication for the treatment of Type 2 diabetes

Members will need to ask their prescribing doctor to contact us to request a prior authorization for the medications listed above. These therapies will require approval starting August 15. If the prescription is not authorized in advance, it may not be covered.

We announced a similar change on February 1, 2023, which didn't apply to members who were already taking these medications. Effective August 15, all members are required to have a prior authorization for these medications.

Providers can request a prior authorization electronically. For more information on how to submit an authorization electronically:

1. Go to ereferrals.bcbsm.com.
2. Select *Blue Cross* for PPO members or *BCN* for HMO members.
3. Click on *Pharmacy Benefit Drugs* on the left.

For a complete list of drugs and coverage requirements go to bcbsm.com/druglists.

Jemperli and Opdualag™ to have site-of-care requirements for BCN commercial members starting July 1

For dates of service on or after July 1, 2023, we're adding site-of-care requirements for Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Jemperli (dostarlimab-gxly), HCPCS code J9272
- Opdualag (nivolumab and relatlimab-rmbw), HCPCS code J9298

When you submit prior authorization requests for these drugs to Carelon Medical Benefits Management (former known as AIM Specialty Health®), the **ProviderPortal®** will prompt you to select a site of care. The request will be approved automatically if it meets clinical criteria for the drug and is for one of the following sites of care:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, when the medication is administered by a home infusion therapy provider

Additional information or documentation may be required for requests to administer Jemperli and Opdualag in an outpatient hospital setting.

As a reminder, these drugs already require prior authorization; providers can submit prior authorization requests to Carelon. The new site-of-care requirements are in addition to the current prior authorization requirements.

For members who start courses of treatment with Jemperli and Opdualag in an outpatient hospital setting before July 1, 2023:

- Those members will be able to continue receiving the drug in an outpatient hospital setting through Jan. 1, 2024.
- After Jan. 1, 2024, those members will need to request prior authorization again and the site-of-care requirements outlined above will apply.

Note: The site-of-care requirements don't apply to Blue Cross Blue Shield of Michigan commercial members.

List of requirements

For additional information on requirements related to drugs covered under the medical benefit, refer to the following Blue Cross commercial and BCN commercial drug lists:

- **Medical oncology prior authorization list for Blue Cross commercial fully insured and BCN commercial members**
- **Blue Cross and BCN utilization management medical drug list**

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

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

Carelon Medical Benefits Management (formerly known as 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.

Pharmacy News

Blue Cross and BCN to use Audaire Health™ provider portal to capture clinical outcomes for CAR-T cell therapy drugs

Starting July 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will start using the Audaire Health provider portal to track and capture clinical outcomes for CAR-T cell therapy drugs for Blue Cross commercial and BCN commercial members.

The data providers enter in the Audaire provider portal will enable Blue Cross and BCN to capture and assess the clinical benefit of these therapies.

Note: This process will replace the manual reporting process for clinical outcomes for CAR-T cell therapy drugs, thereby reducing administrative burden. Blue Cross or BCN will no longer fax forms to prescribing providers on an annual basis for them to enter clinical outcome information and send back to us.

Which CAR-T cell therapy drugs are affected?

Starting July 1, Blue Cross and BCN will require providers to enter clinical outcomes into the Audaire provider portal for the following CAR-T cell therapies, which are covered under members' medical benefits.

HCPCS code	Brand name	Generic name
Q2055	Abecma®	idecabtagene vicleucel
Q2054	Breyanzi®	lisocabtagene maraleucel
Q2056	Carvykti™	ciltacabtagene autoleucel
Q2042	Kymriah®	tisagenlecleucel
Q2053	Tecartus®	brexucabtagene autoleucel
Q2041	Yescarta®	axicabtagene ciloleucel

Notes:

- Current requirements will continue to apply to these drugs. Continue to submit prior authorization requests through the NovoLogix® online tool. (To access NovoLogix, log in to our provider portal (**availity.com**), click on *Payer Spaces* and then click on 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. If you don't have access to Availity®, see the **Register for web tools** page on bcbsm.com.)

Please see Audaire Health™ provider portal continued on Page 17

Pharmacy News

- We'll require that providers enter clinical information in the Audaire provider portal for any CAR-T cell therapy drugs that are approved by the Food and Drug Administration, or FDA, after July 1, 2023.

What will change on July 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 the *How should you prepare for this change?* section below to learn more about attestation.)
- For any member who is approved for one of these therapies, we'll automatically add their basic information to the Audaire provider portal.

  Note: We'll also add basic information for any members who were approved for one of these therapies from Jan. 1, 2022, through June 30, 2023. An Audaire representative will reach out to ask that the requesting provider enter clinical outcome information in the Audaire provider portal for these members.
- Providers or their offices 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:

  - Entering clinical information in the easy-to-use survey format in the Audaire provider portal.
  - Calling 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 July 1 and who have active coverage with Blue Cross or BCN.

Why are we making this change?

CAR-T cell therapies are high-cost treatments, and Blue Cross and BCN recognize the value and therapeutic promise these therapies hold. The goal of collecting this data is to ensure member access to therapies while maintaining affordability.

Do any other drugs require tracking in the Audaire provider portal?

Blue Cross and BCN also require providers to track clinical outcomes for commercial members for the following high-cost spinal muscular atrophy therapies: Zolgensma® (onasemnogene abeparvovec-xioi), Spinraza® (nusinersen) and Evrysdi® (risdiplam). For additional details, see the **October 2022 *Record* article** and the **November-December 2022 *BCN Provider News* article**.

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.

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

The Blue Care Network Generics Advantage Program helps members stay adherent and save money on generics

Through our free Generics Advantage Program, we reward enrolled BCN commercial members with discounts when they follow their doctors' medication treatment plans. (Medicare members are excluded.) The program targets medications for chronic conditions and includes statins, beta blockers and angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers.

This program reduces members' out-of-pocket costs when they fill prescriptions for select generic medications as prescribed. Each time members refill their prescriptions, they may receive bigger discounts and may eventually pay nothing. After their benefits reset in the new year and members remain on targeted medications, they'll continue receiving discounts. The program includes 90-day scripts at retail. It does not include home delivery. See the list of medications in the table below.

How the program works

Members who are adherent to their drug therapies are rewarded with discounts on their prescriptions for certain generic medications. Each time they refill a prescription, they may receive a bigger discount.

Eligible members will receive mailers with program and enrollment information from Sempre Health. They can enroll by text, phone or online to take full advantage of the savings. They receive a discount ID via text or phone call. When this discount ID is shared with a pharmacist, a member will pay a discounted rate for a prescription refill. A member never pays more than his or her typical copay.

List of medications on the Generics Advantage Program:

Medications on the Generics Advantage Program	Dosage
Atenolol tab	100, 25, 50 mg
Atorvastatin Calcium tab	10, 20,40, 80 Mg (Base equivalent)
Carvedilol Phosphate cap ER 24hr	10, 20, 40, 80 mg
Carvedilol tab	12.5, 25, 3.125, 6.25 mg
Lisinopril and Hydrochlorothiazide tab	10-12.5, 20-12.5, 20-25 mg
Lisinopril tab	2.5, 5, 10, 20, 30, 40 mg
Losartan Potassium tab	25, 50 100 mg
Losartan Potassium and Hydrochlorothiazide tab	50-12.5, 100-12.5, 100-25 mg
Metoprolol Succinate Tab ER 24hr	25, 50, 100, 200 mg (Tartrate equivalent)
Metoprolol Tartrate tab	25, 37.5, 50, 75,100 mg
Pravastatin Sodium tab	10, 20, 40, 80 mg
Propranolol HCL tab	10, 20, 40, 60, 80 mg
Propranolol HCL cap ER 24hr	60, 80, 120, 160 mg
Rosuvastatin Calcium tab	5, 10, 20, 40 mg
Simvastatin tab	5,10, 20, 40, 80 mg

This GAP drug list may change or expand in the future.

Michigan Automated Prescription System may not capture all information about a patient's experience with controlled substances

Health care providers using the Michigan Automated Prescription System should know that the database may not capture information about some controlled substances in a patient's history.

Substances not captured by MAPS include:

- Controlled substances administered or dispensed to patients from opioid treatment programs, such as methadone and buprenorphine
- Samples of controlled substances provided to a patient
- Controlled substances dispensed by a doctor at a medical institution for a maximum of 48 hours

MAPS is an interactive database used to track controlled substances, schedule II through V, including gabapentin.

MAPS provides clinicians with important information about a patient's controlled substance prescription history. It can be a valuable tool when considering treatment options and screening patients who may be at risk for abuse or diversion.

For more information on MAPS, visit the **MI Automated Prescription System (MAPS)** website.

BCN and BCN Advantage℠ provider-delivered care management program expands to include specialists

BCN and BCN Advantage have expanded the provider-delivered care management program to specialists retroactive to the beginning of 2023. For dates of service on or after January 1, 2023, specialists can now bill PDCM services for BCN commercial and BCN Advantage members using the following codes:

- HCPCS Codes: G9001, G9002, G9007, G9008, S0257
- CPT Codes: 98961*, 98962*, 98966*, 98967*, 98968*, 99487*, 99489*

Specialists who received a claims denial for one of the above codes for a 2023 date of service for a BCN or BCN Advantage member don't need to take any action. We are already reprocessing these PDCM denied claims.

We updated our systems March 27, so claims with these codes will no longer deny for specialists.

Reminder: Only charge patients their cost share

When you treat a patient with Blue Cross Blue Shield of Michigan or Blue Care Network coverage, including our Medicare Advantage plans, Medicare Plus Blue℠ or BCN Advantage℠, be sure to bill Blue Cross or BCN for covered services and only charge the member the appropriate cost share according to their health plan coverage.

Always ask to see the patient's health plan ID card and check their eligibility and benefits through one of these methods:

- *Eligibility and Benefits Inquiry* in our provider portal
- Provider Inquiry
  - Professional providers: 1-800-344-8525
  - Hospital and facility providers: 1-800-249-5103
- Electronic standard transaction

You can use these sources to determine the appropriate member cost share, including deductible, coinsurance and copay prior to providing the service, then you can charge the member the correct amount at the time of service. As an alternative, you can provide the service, submit the claim and wait for the remittance advice or voucher to explain the member's cost share before billing the member. If you wait to bill the member, be sure to check that the member's coverage is active and that the service you're providing is a covered benefit before providing the service.

Our provider agreements prohibit participating, or contracted, providers from charging Blue Cross or BCN members any amounts beyond the member's applicable cost share. If the remittance advice or voucher indicates the member's cost share should have been less than what you charged, you will need to refund the member the overcharged amount.

Change to member reimbursement

Blue Cross and BCN are changing the way we manage reimbursement requests from members with Blue Cross and BCN commercial coverage. When a member sends in a request for reimbursement, we'll look to see if the health care provider is a participating or contracted provider. If that is true, we'll direct payment to the provider. The provider will then need to reimburse the member.

If your practice has been asking patients to pay for the service and request reimbursement from us, this will result in additional work for you.

BCN changing check reference ID in claim status options

When you view your Blue Care Network or BCN Advantage℠ remittance advices, vouchers, 835 electronic remittance advice transactions or your BCN Negative Balance Report, you may notice a new format in the "Check Reference ID" field.

This field is a series of numbers used to identify a specific check. Currently, the digits in this field begin with the check payment date shown in this format: YYYYMMDD, where September 1, 2023 is listed as 20230901. This is followed by eight additional digits.

You don't need to use this field to determine the check payment date as this information is available elsewhere in each document or report. For example, a BCN voucher has a "Date" field at the top with the check payment date in an easy-to-understand format.

For electronic transactions, the check reference ID that is changing will be reflected in the TRN02 segment, known as the check or EFT trace number. The date format is unchanged in the BPR16 segment displaying the check issue or electronic fund transfer effective date.

We don't expect the change to the format of the check reference ID to affect your ability to use any of the BCN claim status options. There's also no change to the way you look up a claim status document.

If you're curious about the new BCN check reference ID format, read on.

Check reference ID will include the check payment date displayed in Julian date format

The new format for the check reference ID, which is expected to begin August 13, lists a two-digit year followed by the month and day displayed in a three-digit Julian date format. The combined year and month/day results in a five-digit Julian date which is followed by 11 additional alphanumeric digits.

What is a Julian date?

A Julian calendar counts 365 days per year with an additional leap day added every four years. Jan. 1 is day 1. Each day after that adds another number. Thus, Feb. 1 is day 32, March 1 is day 60, etc., until we end the year on Dec. 31 at day 365 (in a non-leap year).

While most of us follow a Gregorian calendar, some information technology uses the Julian calendar. BCN's claims payment system is undergoing an upgrade that will result in the "Check Reference ID" field being displayed as a Julian date.

Here's how you may see the September 1, 2023 date in our old and new formats:

- Old format: 20230901**1**0300531
- New format: 23244B1000000531

The date is highlighted in both. Note that the new format has an alpha character following the date (either a B or an S). This is used only by BCN.

How can I translate a Julian date?

There are several online sources that will translate between Gregorian and Julian calendar dates. Here are some examples you can use:

- **CalendarLabs.com 2023 Yearly Julian Calendar**
- **101planners.com 2023 Julian Calendar**
- **Longpela Expertise**

Billing Bulletin

BCN Provider *News*

Feedback

Clinical editing billing tips

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

This issue's tips:

- New clinical edits for drugs and biologicals
- Update to multiple radiology professional reads
- Updates on a claim that may trigger a new clinical edit

Clinical Editing Billing Tips

Balance billing by noncontracted ambulance services continues to stress patients

As a reminder, providers must order transfers from contracted ambulance services when arranging for non-emergency ground transfers to prevent patients from being balanced billed large amounts from noncontracted ambulance services.

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

Behavioral health providers: How to bill prolonged services

In January 2023, we posted a provider alert in which we asked behavioral health providers to hold claims for dates of service on or after Jan. 1, 2023, that contain procedure codes *99354 and *99355. These codes were for prolonged services and were terminated as of Jan. 1, 2023.

See the article on **Page 13** for details.

We'll use 2023 InterQual® criteria starting Aug. 1

On Aug. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2023 InterQual criteria to make determinations on prior authorization requests for the behavioral health and non-behavioral health services we manage.

Note that this information applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by independent companies that provide services to Blue Cross Blue Shield of Michigan.

Non-behavioral health services

We'll use updated criteria for all levels of care to make determinations on prior authorization requests for non-behavioral health services for the following members:

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

When clinical information is requested for a medical or surgical admission or for other services, we require providers to submit the specific components of the medical record that show that the request meets the criteria. We review this information when making determinations on prior authorization requests.

Blue Cross and BCN also use local rules, which are modifications of InterQual criteria, in making determinations. You can access the local rules as follows:

- On the Blue Cross **Authorization Requirements & Criteria** page of ereferrals.bcbsm.com. Look in both the Blue Cross commercial and the Medicare Plus Blue sections of that page.
- On the BCN **Authorization Requirements & Criteria** page of ereferrals.bcbsm.com. Look under the "Referral and authorization information" heading.

Refer to the table below for more specific information about which criteria we use in making determinations for various types of non-behavioral health prior authorization requests.

Note that starting Aug. 1, we'll no longer use the condition-specific local rules for acute inpatient medical admissions.

Criteria	Services
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
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

Please see 2023 InterQual® continued on Page 24

Behavioral health services

On Aug. 1, 2023, we'll begin using the 2023 InterQual criteria to make determinations on prior authorization requests for behavioral health services for these members:

- Medicare Plus Blue
- BCN commercial
- BCN Advantage

In addition, certain 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	• Mental health disorders: partial hospital 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 • Neurofeedback for attention deficit disorder and attention deficit hyperactivity disorder • Transcranial magnetic stimulation, or TMS • Telemedicine (telepsychiatry and teletherapy)
Medicare Plus Blue	Mental health disorders: partial hospital program	Telemedicine (telepsychiatry and teletherapy)

You can find links to the current modified behavioral health and autism local rules and to the medical policies on these webpages:

- **Blue Cross Behavioral Health page**
- **BCN Behavioral Health page**
- **Blue Cross Autism page**
- **BCN Autism page**

We'll update those pages prior to Aug. 1 to reflect the criteria changes.

Note: Determinations on Blue Cross commercial behavioral health authorization requests are handled by New Directions Behavioral Health®. 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.

Carelon to expand existing prior authorization program starting Sept. 1

For dates of service on or after Sept. 1, 2023, additional services will require prior authorization by Carelon Medical Benefits Management (formerly known as AIM Specialty Health®).

Carelon currently manages select services for Blue Cross Blue Shield of Michigan commercial, Blue Care Network commercial, Medicare Plus Blue℠ and BCN Advantage℠ members.

Here's a summary of the changes that will occur starting Sept. 1:

- For both Blue Cross and BCN commercial members, additional cardiology, advanced imaging and sleep study services will require prior authorization.
- For BCN commercial members, Carelon will start managing in-lab sleep studies.

By Aug. 14, the Carelon ProviderPortal® and the Carelon call center will be ready to accept prior authorization requests for these additional services.

These changes apply to:

- Most Blue Cross Blue Shield of Michigan commercial members
- All Blue Care Network commercial members

For the services that Carelon already manages, you'll continue to request prior authorization through the Carelon ProviderPortal.

Look for additional details about these changes in upcoming provider alerts and newsletter articles.

Carelon Medical Benefits Management (formerly known as 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.

Reminder: Prior authorization changes began June 1

Michigan's **prior authorization law requirements** went into effect on June 1, 2023. These requirements apply to health care insurers and providers in Michigan for members who have commercial coverage.

One of the requirements of the law is that providers must submit prior authorization requests electronically. If providers are unable to submit electronically due to temporary technical problems, such as power or internet outages, they can submit via alternate methods, such as phone or fax. For alternate submission methods, see the appropriate page of our **ereferrals.bcbsm.com** website.

The law also requires health care insurers to:

- Provide a list of services that require prior authorization and the clinical criteria used to make determinations on prior authorization requests. This information is available at **bcbsm.com/priorauth**.
- Make determinations on standard (non-urgent) preservice prior authorization requests within nine days of receiving a request. We began doing this June 1.

  With this shorter timeframe, it is crucial that you submit all necessary clinical documentation when you enter the request on e-referral. This will prevent denials due to lack of information and, as a result, will decrease the need to file appeals.

We communicated this information and more about the requirements of the law in previous issues of this newsletter and in the provider alert titled **Update: Prior authorization changes coming in June**.

Questionnaire changes in the e-referral system

From March through May, we added, updated and removed questionnaires in the e-referral system. We also added, updated and removed 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 questionnaire

On March 26, we added a Breast reduction questionnaire that's specific to BCN Advantage members. This questionnaire opens for adolescent and adult BCN Advantage members for procedure code *19318.

Updated questionnaires

We updated the following questionnaires on the date specified below:

Questionnaire	Opens for	Updates	Release date
Abdominoplasty	• BCN commercial • BCN Advantage	Added a question.	5/14/2023
Bone-anchored hearing aid	• BCN commercial • BCN Advantage	Updated several questions.	5/14/2023
Breast reduction	BCN commercial	No longer opens for BCN Advantage members. This questionnaire continues to open for procedure code *19318 for BCN commercial members. As noted above, a separate questionnaire opens for BCN Advantage members.	3/26/2023
Cosmetic and reconstructive surgery	• Medicare Plus Blue • BCN commercial • BCN Advantage	• Updated some questions. • Deleted a question.	4/24/2023
Dental general anesthesia or repair of trauma to natural teeth	• BCN commercial • BCN Advantage	Updated the wording of a question.	4/9/2023
Endovascular intervention, peripheral artery	• Medicare Plus Blue • BCN commercial • BCN Advantage	• Updated the wording of a question.	3/26/2023
		• Providers can request only 2 units per procedure code.	5/14/2023
Excess skin removal	• BCN commercial • BCN Advantage	Updated several questions.	5/14/2023
Experimental and investigational services	• BCN commercial • BCN Advantage	Opens for both pediatric and adult members.	5/1/2023

Please see Questionnaire changes continued on Page 27

Referral Roundup

Questionnaire	Opens for	Updates	Release date
Hammertoe correction surgery	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Oral surgery	• BCN commercial • BCN Advantage	Updated a question.	5/14/2023
Otoplasty	• BCN commercial • BCN Advantage	Updated a question.	4/24/2023
Pediatric feeding program	BCN commercial	Updated a question.	4/24/2023
Prostatic urethral lift	• BCN commercial • BCN Advantage	• Updated the wording of a question. • Removed a question.	3/26/2023
Radiofrequency ablation (RFA), cardiac atrial fibrillation or atrial flutter	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of a question.	4/9/2023
Radiofrequency ablation (RFA), cardiac frequent monomorphic premature ventricular contractions	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Radiofrequency ablation (RFA), cardiac nonsustained ventricular tachycardia	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Radiofrequency ablation (RFA), cardiac suspected AVNRT, AVRT or focal atrial tachycardia	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Radiofrequency ablation (RFA), cardiac sustained (more than 30 seconds) ventricular tachycardia	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Radiofrequency ablation (RFA), cardiac treatment for preexcitation syndrome or WPW syndrome	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Responsive neurostimulator/ deep brain stimulation trigger questionnaire	• BCN commercial • BCN Advantage	No longer opens for procedure code *61868.	3/26/2023
Responsive neurostimulation for the treatment of refractory partial epilepsy	• BCN commercial • BCN Advantage	No longer opens for procedure code *61868.	3/26/2023

Please see Questionnaire changes continued on Page 28

Questionnaire	Opens for	Updates	Release date
Rhinoplasty	• Medicare Plus Blue • BCN commercial • BCN Advantage	Deleted a question.	4/24/2023
Thyroidectomy, partial	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of some questions.	4/9/2023
Thyroidectomy, total	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated the wording of a question.	4/9/2023
Varicose vein treatment	• BCN commercial • BCN Advantage	• Opens for procedure code *37799. • Updated the wording of some questions.	3/26/2023

Removed questionnaires

- On March 26, we removed the *Blepharoplasty, lower lid* questionnaire. Although this service continues to require prior authorization for Medicare Plus Blue, BCN commercial and BCN Advantage members, this questionnaire no longer opens.
- On May 14, we removed the *Cholecystectomy (laparoscopic)* questionnaire for BCN commercial and BCN Advantage members. Plan notification is required for procedure codes *47562, *47563 and *47564, but no clinical review is performed.

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time. To access them, go to ereferrals.bcbsm.com, and for:

- BCN

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

- Medicare Plus Blue

  Click *Blue Cross* and then click **Authorization Requirements & Criteria**. Scroll down and 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 accessible from the Authorization Requirements & Criteria pages.

Referral Roundup

Updates to list of musculoskeletal procedure codes that require prior authorization

We recently updated the **Musculoskeletal procedure codes that require authorization by TurningPoint** document to reflect the following changes:

- For dates of service on or after March 19, 2023, procedure code *64625 is no longer payable for Medicare Plus Blue or BCN Advantage members.

  Note: This procedure code continues to be payable for commercial members. It requires prior authorization for BCN commercial members. It doesn't require prior authorization for Blue Cross commercial members.
- For dates of service on or after March 25, 2023, procedure code C1767 doesn't require prior authorization for Medicare Plus Blue, BCN commercial or BCN Advantage members.

  Note: This procedure code has never required prior authorization for Blue Cross commercial members.
- For dates of service on or after July 1, 2023, procedure code *0775T will require authorization for Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members.

For more information about TurningPoint's musculoskeletal surgical quality and safety management program, see the following pages on the 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.

Referral Roundup

BCN Provider *News*
Feedback

Updated medical record documentation guidelines for musculoskeletal procedures

In February 2023, Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Healthcare Solutions LLC updated the guidelines for medical record documentation for musculoskeletal procedures as follows:

- Each entry in the office visit notes must include the author, the appropriate signature and the date.
- Surgical candidates must be seen by the surgeon during the four months prior to the date on which the procedure is performed.
  - For established patients who have previously seen the surgeon in person, this can be a telemedicine visit or an in-person visit.
  - For new patients or patients who haven't previously seen the surgeon in person, this must be an in-person visit.

  Note: Previously, candidates had to be seen by the surgeon during the three months prior to the date on which the procedure was performed.

To view the updated requirements document, see the document titled **GN-1002 Medical Record Documentation**, which is available on the Musculoskeletal Services pages of our ereferrals.bcbsm.com website.

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.

Some pre-COVID-19 utilization management requirements to resume July 1

With the end of the COVID-19 public health emergency, or PHE, Blue Cross Blue Shield of Michigan and Blue Care Network will reinstate utilization management requirements that were in effect before the PHE.

See the article on **Page 1** for details.

Submit prior authorization requests for ABA services through e-referral

Beginning June 1, 2023, licensed behavior analysts, or LBAs, in Michigan must submit prior authorization requests for applied behavior analysis, or ABA, services through the e-referral system. This affects LBAs who provide ABA services to BCN commercial members.

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

Jemperli and Opdualag™ to have site-of-care requirements for BCN commercial members starting July 1

For dates of service on or after July 1, 2023, we're adding site-of-care requirements for Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Jemperli (dostarlimab-gxly), HCPCS code J9272
- Opdualag (nivolumab and relatlimab-rmbw), HCPCS code J9298

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

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HEALTHY mind

Blue Cross and BCN behavioral health changes coming Jan. 1, 2024

Starting Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will consolidate the prior authorization and case management functions for behavioral health services, including treatment for autism. This change will affect all members:

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

The consolidation will result in two new programs that will align and standardize prior authorization and case management functions for all lines of business. This will make it easier for you to manage your administrative functions for Blue Cross and BCN patients. As part of this change, Lucet (New Directions) will no longer manage these functions for Blue Cross commercial members.

What are the names of the new programs?

The new programs are:

- Blue Cross Behavioral Health℠ – will manage prior authorizations for behavioral health services, including treatment for autism
- Blue Cross Coordinated Care℠ – will handle behavioral health care management

What changes will providers and members see?

Here are some changes to expect:

- Providers will submit prior authorization requests through our provider portal (availity.com).
- We'll no longer require routine faxing or electronic submission of discharge summaries.
- Providers and members may notice some changes in notification letters, such as those sent when prior authorization requests are approved or denied.
- Members currently enrolled in behavioral health case management services may be assigned a new case manager in January. The members affected by this change will be notified.

There will be no changes to:

- Provider networks
- Provider reimbursement
- Members' coinsurance, copayments, or deductibles

Please see Blue Cross and BCN behavioral health changes coming Jan. 1, 2024 *continued on Page 2*

Inside this issue…

SEPTEMBER-OCTOBER 2023

BCN Provider News

Blue Cross and BCN behavioral health changes coming Jan. 1, 2024, *continued from Page 1*

- The phone numbers providers and members use to contact Blue Cross or BCN regarding prior authorization or case management. Voice prompts will direct callers to make one of these selections:
  - For services prior to Jan. 1, 2024
  - For services after Dec. 31, 2023

What's changing for prior authorization requests?

For autism treatment services: Because prior authorizations for autism treatment services are typically approved for a longer period of time than for other services, we began handling them differently, starting in July, to ensure we can transition them into the new system.

- As of July 2023: Prior authorizations for autism treatment services are approved for shortened times — that is, for less than the typical six-month time period.

Starting in November 2023:

- Blue Cross Behavioral Health will manually enter cases into the new system.
- Each "new" case will be created with a "start" or "admission" date of Jan. 1, 2024. Providers must include the new date in claims submissions for services provided in 2024.
- Providers and members will receive letters that will reflect authorizations for the remainder of the typical six-month period that was shortened due to the transition to the new system.

Starting in 2024:

- Providers should request their next authorization or concurrent review based on the end date cited in the authorization letter they received in November or December.

Note: For BCN commercial members, providers will continue to submit authorization requests and information updates for autism treatment services through our provider portal (availity.com). Faxes won't be accepted.

For services other than autism treatment:

- For some services that require prior authorization and will continue into 2024, providers will need to obtain a new prior authorization. These prior authorizations will have a new "start/admission date," which providers must include in claims submissions for services provided in 2024. This applies to:
  - Partial hospitalization program services for Blue Cross commercial and Medicare Plus Blue members
  - Transcranial magnetic stimulation, or TMS, services for Blue Cross commercial members
- For other services that require prior authorization and have start dates or dates of service before Jan. 1, 2024, providers should submit requests for prior authorization and reviews of continued stays using the same processes they're currently using.
- For intensive outpatient services for Medicare Plus Blue, BCN commercial and BCN Advantage members, prior authorization won't be required starting Jan. 1, 2024.
- For neurofeedback services for BCN commercial and BCN Advantage members, prior authorization won't be required starting Jan. 1, 2024.

Additional information

Look for more information about these and other changes in upcoming newsletter articles.

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

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Network Operations

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 liaisons 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 Blue Cross or BCN medical director**. To discuss an urgent case after normal business hours, call the appropriate number:

- For medical cases (non-behavioral health) — 1-800-851-3904
- For behavioral health — 1-877-293-2788

How to obtain a copy of utilization management criteria

Upon request, Blue Care Network provides 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. (Note: This applies to non-behavioral health authorization requests only.)

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

InterQual® criteria is available to all practitioners and providers through our provider portal (availity.com).

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

Network Operations

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.

BCN staff available to our members for utilization management issues

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

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 for those who don't speak English and TDD/TTY assistance for the hearing and speech impaired free of charge to discuss utilization management issues with our members.

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

Subscribe now for Provider Alerts Weekly email

Provider alerts offer you information you need to know between newsletters. Housed on the secure Provider Resources website, they're accessed through the payer space on our provider portal. Through recent research, office staff shared that a weekly email with links to our provider alerts would be helpful.

You can subscribe now to receive *Provider Alerts Weekly*, a list of links to the previous week's provider alerts from Blue Cross Blue Shield of Michigan and Blue Care Network. Beginning this fall, the email will give you a week's worth of headlines as links so you can view the details for the alerts that interest you.

Go to the **Subscribe to Provider Newsletters** webpage to sign up for *Provider Alerts Weekly* emails and then look for the emails to start arriving soon.

Reminder: Health care providers must confirm data every 90 days and attest in CAQH every 120 days

What you need to know

To remain listed in Blue Cross Blue Shield of Michigan provider directories, including *Find a Doctor*, health care providers must re-attest every 120 days.

Have you confirmed data within the past 90 days and attested in CAQH within the past 120 days? If health care providers don't re-attest with CAQH every 120 days, they won't be included in Blue Cross Blue Shield of Michigan provider directories. This includes our *Find a Doctor* search tool. Please note that your credentialing status will end, and you'll have to reapply. That's why it's so important to perform this task.

Here are some other reasons to re-attest with CAQH:

- Ensure that your affiliation with Blue Cross isn't interrupted.
- Keep your contact information up to date.
- Make sure claims payment isn't interrupted.

Regardless of whether providers are practicing at an office location or exclusively in an inpatient hospital setting, they need to perform this attestation.

If you're practicing exclusively in an inpatient hospital setting, you must indicate it on your CAQH application. This information is used to determine whether full credentialing is required.

CAQH is a nonprofit alliance of health plans and trade associations focused on simplifying health care administration. Blue Cross uses CAQH to gather and coordinate our practitioner credentialing information. All health care practitioners, including hospital-based providers, need to be registered with CAQH.

If you have questions about CAQH, call the Help Desk at 1-888-599-1771, or go to **CAQH.org**.

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 opportunities:

Our Lunch & Learn sessions from May and June have been recorded and posted on the training website. Both sessions focus on coding changes and provide scenario examples. Please search 'lunch' to quickly locate these sessions.

- Coding neoplasms
- Coding diabetes and hypertension

Check the dashboard on our provider training site for announcements as we add more courses, including those with CME offerings. The site is available to enhance the training experience for health care providers and staff.

To request access to the training site, 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**.

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

As a reminder, we're offering live, 30-minute educational webinars that provide updated information on documentation and coding for common challenging diagnoses. Webinars include an opportunity to ask questions.

Here's our upcoming schedule and tentative topics for the webinars. Each session starts at noon Eastern time. Log in to the provider training website to register for sessions that work with your schedule.

Session date	Topic
Sept. 20	Coding tips for COPD and asthma
Oct. 18	ICD-10-CM updates and changes for 2024
Nov. 15	Coding chronic kidney disease and rheumatoid arthritis
Dec. 13	CPT coding scenarios for 2024

Please see Lunch and learn webinars *continued on Page 7*

Lunch and learn webinars, *continued from Page 6*

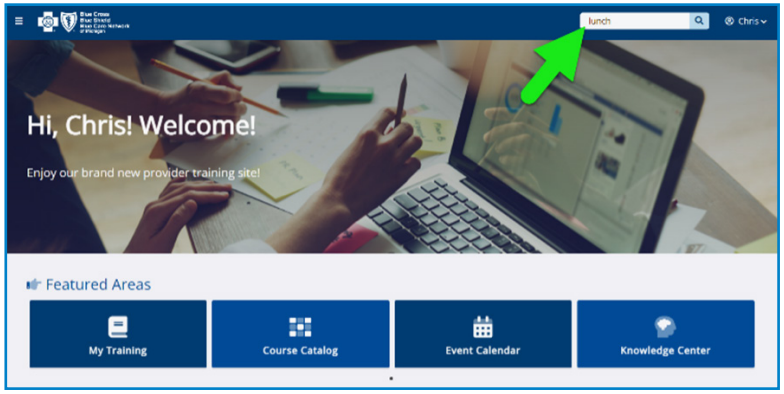
If you haven't already registered for the provider training website, follow these steps:

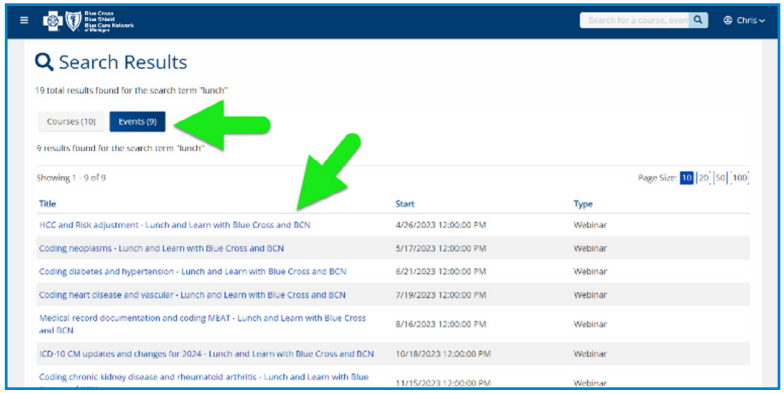
- **Click here to register**.
- Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan for other needs. This will become your login ID.

Locating a session

Click here if you are already registered for the provider training website. On the provider training website, look in the *Event Calendar* or use the search feature using the keyword "lunch" to quickly locate all 2023 sessions.

See the screenshots below for more details.





Previous sessions

You can also listen to previously recorded sessions. Check out the following:

Date	Topic
April 26	HCC and risk adjustment coding scenarios
May 17	Coding neoplasms
June 21	Coding diabetes and hypertension
July 19	Coding heart disease and vascular
Aug 16	Medical record documentation and MEAT

For more information

If you have any questions about the sessions, contact April Boyce at aboyce@bcbsm.com. If you have questions about a session or website registration, email ProviderTraining@bcbsm.com.

Network Operations

Help patients avoid a gap in coverage due to Medicaid redetermination

During the COVID-19 public health emergency, the Families First Coronavirus Response Act mandated that Medicaid programs maintain continuous enrollment for individuals. Now that the public health emergency has ended, all Medicaid and Healthy Michigan Plan members must go through a Medicaid redetermination process. This began in June 2023 and will run through May 2024. Monthly renewal notices are sent three months before a member's renewal date.

Blue Cross Blue Shield of Michigan, Blue Care Network and our Medicaid health plan, Blue Cross Complete, encourage you to help your patients with Medicaid and Healthy Michigan Plan coverage understand the Medicaid redetermination process. This process verifies whether members still qualify for coverage. Those who no longer meet the eligibility criteria can be disenrolled.

Blue Cross wants to help your patients understand the process and learn about various options that may be available if they lose eligibility.

To learn more:

- Patients can visit **bcbsm.com/Medicaidchange** or call **1-855-401-4456**
- Providers can read ***Medicare eligibility redetermination***

Blue Cross and BCN behavioral health changes coming Jan. 1, 2024

Starting Jan. 1, 2024, Blue Cross and BCN will consolidate the prior authorization and case management functions for behavioral health services, including treatment for autism. This change will affect all members, including those with BCN Advantage℠ coverage.

See the **cover story** for details.

Medicare Advantage members in crisis to get new options for behavioral health care treatment

Starting Jan. 1, 2024, our Medicare Advantage members (Medicare Plus Blue℠ and BCN Advantage℠) will have some new options for receiving help if they're having a behavioral health crisis, as part of our crisis services program.

See the article on **Page 20** for details.

Blue Cross and BCN begin using Quartet to help connect members with behavioral health providers

Blue Cross Blue Shield of Michigan and Blue Care Network are now using Quartet, an independent company, to assist our members who are seeking outpatient care for mental health or substance use disorders. Quartet's services are available to BCN Advantage℠ adult members (18 years of age or older) residing in Michigan.

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

Pediatrician uses pharmacogenomics to help patients

Blue Care Network's new Blue Cross Personalized Medicine℠ program offers eligible BCN and BCN Advantage℠ patients a free RightMed® PGx test using the patient's genetics to help customize medications.

We recently spoke with Sharon McManus, D.O., F.A.A.P., of Pediatric HealthCare in Sterling Heights about her experience with PGx.

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

Medicare Advantage members receive in-home test kits

Blue Cross Blue Shield of Michigan and Blue Care Network are contracting with Everlywell, a third-party vendor, to distribute in-home test kits in September to select Medicare Advantage members. A fecal immunochemical test, or FIT, kit will be sent to members who need colorectal cancer screening, and an HbA1c test kit will be sent to those who need a hemoglobin A1c test. Everlywell will send providers a copy of their patients' results through mail or fax.

Requirements and codes changed for some 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 comprehensive lists of requirements for our members.

In April, May and June of 2023, we added requirements for some medical benefit drugs. These requirements went into effect on various dates.

See the article on **Page 23** for details.

Elahere, Imjudo, Tecvayli, Lunsumio to require prior authorization for most members starting Aug. 23

For dates of service on or after Aug. 23, 2023, the following drugs require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members:

- Elahere™ (mirvetuximab soravtansine-gynx), HCPCS code J9063
- Imjudo® (tremelimumab-actl), HCPCS code J9347
- Tecvayli™ (teclistamab-cqyv), HCPCS code J9380
- Lunsumio™ (mosunetuzumab-axgb), HCPCS code J9350

These drugs are covered under the members' medical benefits, not their pharmacy benefits.

See the article on **Page 26** for details.

Changes for in-lab sleep studies to start Oct. 9

Prior authorization requirements for in-lab sleep studies will change for dates of service on or after Oct. 9, 2023. For BCN Advantage℠ members, prior authorization will be required for providers who are out of network for the member's plan.

See the article on **Page 32** for details.

Sharon McManus, D.O. and patient Aria McGhee

Photo by Joe Coots

Pediatrician uses pharmacogenomics to help patients

For some Blue Care Network physicians, pharmacogenomics — the science of using a patient's genetics to help customize medications — is a new concept. However, Sharon McManus, D.O., F.A.A.P., of Pediatric HealthCare in Sterling Heights, had her introduction to pharmacogenomics, or PGx, several years ago. So when BCN introduced the new Blue Cross Personalized Medicine℠ program that offers eligible BCN and BCN Advantage℠ patients a free RightMed® PGx test, she was on board.

Here's what Dr. McManus told us about her experience with PGx for pediatric patients in a recent interview.

What are the benefits of PGx?

- **Saving time**

  One of the biggest benefits of PGx, according to McManus, is its ability to save time.

  "A lot of the mood stabilizing medications, which are desperately needed these days, as well as a lot of the neurology medicines, are often times trial and error," she explained. "So, what's best for this particular patient? There are a lot of choices and if there's metabolism that can predict for us that a patient is going to have a better response, then not only might the patient benefit specifically but it's a lot less visits to the office and a lower cost of wasted time and medication in getting to the right therapy."

Please see Pediatrician uses pharmacogenomics *continued on Page 12*

Pediatrician uses pharmacogenomics, *continued from Page 11*

- **Fewer side effects**

  According to McManus, "Medications are utilized by the body differently from person to person. That genetic component of the metabolism can affect how well a medication works for a person. If their body metabolizes it as expected, then we expect it to work for them with less side effects."

- **Providing reassurance about treatment options**

  "Often patients are resistant to medication for psychiatric diagnoses," said McManus. She explained that parents often don't want to put their children on medication for anxiety, depression or attention problems "because they're worried about the side effects, and they're worried that they're not making a good choice for their child." PGx is helpful to parents because it offers them "the reassurance of making a good, informed choice."

What is your experience with PGx?

McManus has experience with PGx both as the prescriber and when the prescriber is a specialist.

When the prescriber is a specialist, her office staff uploads the PGx results into the patient's medical record and communicates to the specialist that the information is available. If the patient is being treated by a psychiatrist who doesn't have access to the patient's medical record, McManus says her office will either "give the information to the parents or the parents have the information from the performing lab with its interpretation to share with the [psychiatrist]."

McManus said the specialists she's spoken to have found PGx useful.

How have the PGx results assisted you in coordinating care for your patients?

McManus gave the example of a patient who was on a selective serotonin reuptake inhibitor, or SSRI, and experiencing many unwanted side effects. The results of the PGx test were helpful in switching that patient to a different class of medication that reduced their side effects.

How does the process work for authorizing the RightMed test for patients in your office?

"When we get the list from Blue Cross about the eligible patients, I review it and have a discussion with the medical assistant and nurse about what I think might be helpful for the individual," she explained. "If I'm seeing [the patient], then I'll talk to them about [PGx] but if I just want the parents to know that it's available, I'll have one of the medical assistants call." Sometimes McManus will reach out to the family and have the discussion if she thinks it's something they need to consider.

"Usually, the families that are identified are families we know pretty well so it's easy for us to have that conversation," explained McManus.

McManus also said that "it was a smooth transition to get [her office] on board with the RightMed tests," because she has a triage medical assistant and a nurse who are already familiar with genetic testing and able to answer patients' questions.

How do parents feel about the test?

Although McManus acknowledged that pharmacogenomics can be worrisome to some people who are concerned about privacy issues, she said she's also had patients request genetic testing. They want to know if the medicine they're giving their child is the best one.

Does it take a lot of time online to complete the test request, authorize the test and access the information?

"It really doesn't take that long," said McManus. "My understanding from the nurse is that the family sets up an account and she can process the order from there. So, I'm giving the verbal [order] to do that."

Sharon McManus, D.O.

Photo by Joe Coots

Please see Pediatrician uses pharmacogenomics *continued on Page 13*

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Pediatrician uses pharmacogenomics, *continued from Page 12*

What is your advice to other primary care physicians about authorizing PGx tests?

Staff support is important, explained McManus. "If there is a staff member who is comfortable handling the discussion with the parent, I find that really beneficial. Identifying someone who's capable of having that conversation is wise."

Based on your experience, how do you feel about PGx?

"Overall, I'm pleased to have the information [from PGx test results]," said McManus. "I think that the information can be intimidating for people who know little about PGx, but the assistance that we've had from the performing labs in interpretation has been really helpful. So, I find it only positive."

What do you see as the future of PGx?

While McManus admitted that PGx is in a "baby stage," and incorporating it into physicians' practices is still a "work in progress," she said she sees the program expanding in the future.

Photo by Joe Coots

The Pediatric HealthCare team. From left: Marrisa Lester, medical receptionist; Rebekka Parker, HR office manager; Amanda McGhee, patient registration, referral & PA specialist; Amy Gottschalk, FNP-C; Chris Love, medical receptionist; Sharon McManus, DO, physician owner; Jeanette Nicol, medical assistant; Nuzhat Mustaque, medical receptionist; Caitlyn Dent, RN; Branden Swarmer, medical assistant; Mark Deprez, MD, physician owner; Tiffany Downey, medical assistant.

Providers not pictured: Robin Hugen, MD, physician owner; Rebecca Wegner, MD, physician owner; Naba Alibeji, MD; Carolyn Grabiel, CPNP; Nirali Mody, CPCP-PC.

Diabetes remission program for select BCN commercial members

Starting Sept. 1, 2023, select Blue Care Network commercial members who have coverage through fully insured groups and have Type 2 diabetes will be eligible for a diabetes remission program through Twin Health.

The goal of the program is to help members achieve and maintain a state of diabetes remission — as opposed to using traditional methods to treat and manage diabetes.

To do this, Twin Health:

- Creates a "digital twin" of a member's unique physiology using an artificial intelligence algorithm to provide customized, real-time guidance on nutrition, sleep and physical activity.
- Provides consultation services to members by phone and through a mobile app.

Twin Health services are intended to complement care provided by the member's primary care provider.

Twin Health will contact your practice if you have patients with Type 2 diabetes who are eligible for this program and have agreed to participate.

For additional information about this program, email **pcpinfo@twinhealth.com**.

Twin Health is an independent company that provides a diabetes remission program for Blue Cross Blue Shield of Michigan and Blue Care Network.

Overview of Family Building and Women's Health Support Solution

In 2023, Blue Cross Blue Shield of Michigan and Blue Care Network worked with Maven to provide the Family Building and Women's Health Support Solution to eligible commercial members.

This solution includes programs that support members of all backgrounds and lifestyles through four important stages of life — building a family, pregnancy, parenting and menopause.

We recently published a document titled **Family Building and Women's Health Support Solution: Overview for providers**. It provides more detailed information than the articles we previously ran in our provider newsletters and provider alerts. If there are changes to the programs, we'll update this document to reflect the changes.

You can access the document linked above in the "Care management" section of the **For Providers: Forms and Document** page of the **bcbsm.com** website.

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

Physician appointment access survey in process

Blue Cross Blue Shield of Michigan and Blue Care Network must meet requirements of several regulatory or accreditation bodies, such as the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services and the state of Michigan. To do so, we're reaching out to some physician offices to request the completion of an *Appointment Access Survey* for each physician in the office. Your office may receive a phone call or a fax request to complete the survey. Your participation is important to demonstrate that you are meeting regulatory requirements.

Here are the physician specialties that will be included in the survey. If you have physicians with these specialties, you can follow the instructions below to complete the survey before we contact you.

Primary care

- Family practice
- General practice
- Internal medicine
- Pediatrics

Specialists

- Cardiovascular disease
- Dermatology
- Obstetrics-gynecology
- Oncology
- Ophthalmology
- Orthopedic surgery
- Podiatry

Be sure to complete a separate survey for each physician in the office.

Please see Physician appointment access survey in process *continued on Page 16*

Physician appointment access survey in process, *continued from Page 15*

How to access the survey

Type of physician	Click this link	Or scan this QR code
Primary care	***Primary Care Appointment Access Survey***	
Specialist	***Specialist Appointment Access Survey***	

Review appointment access standards

You can review appointment access standards in our provider manuals. Here's how to find them.

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

For the *Blue Cross Commercial Provider Manual*:

1. Click *Blue Cross commercial*.
2. Scroll down to the *PPO Policies* chapter under *Quality Standards and Clinical Guidelines*.
3. Click *Access standards* in the table of contents.

For the *BCN Provider Manual*:

1. Click *BCN commercial and BCN Advantage*℠.
2. Scroll down to the *Access to Care* chapter.

For the *Medicare Plus Blue*℠ *PPO Provider Manual*:

1. Click ***Medicare Plus Blue*℠ *(PDF)***.
2. Click *Access to Care* in the table of contents.

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

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.

The Michigan Quality Improvement Consortium guidelines are 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.

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 also 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 that 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 Utilization 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.

Patient Care/ Quality

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 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

- Bone Marrow Transplant - Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia
- Blephoplasty and Repair of Brow Ptosis
- Bone Marrow Transplant-Hematopoietic Cell Transplantation for Myelodysplastic Syndromes and Myeloproliferative Neoplasms, Allogeneic
- BMT- Hematopoietic Cell Transplantation (HCT) for CNS Tumors, Embryonal Tumors, and Ependymoma
- Genetic Testing - Human Leukocyte Antigen Testing for Celiac Disease
- Artificial Intervertebral Discs - Lumbar Spine
- Bioimpedance Devices for Cancer Related Extremity Lymphedema
- Bone Marrow Transplant - Hematopoietic Cell Transplant for Genetic Diseases and Acquired Anemias, Allogeneic
- Bone Graft Substitutes
- Bone Morphogenetic Protein
- Bone Turnover Markers for Diagnosis and Management of Osteoporosis and Diseases Associated with High Bone Turnover
- Bronchial Valves
- Cognitive Rehabilitation
- Diagnosis of Vaginitis (including Bacterial Vaginosis, Trichomonas and Candidiasis) Using Multi-target PCR Testing
- Gene Expression Profiling for Cutaneous Melanoma
- Noninvasive Techniques for the Evaluation and Monitoring of Patients with Chronic Liver Disease
- Private Duty Nursing

Noncovered services

- Low-Dose Radiofrequency for Nasal Valve Remodeling
- Measurement of Serum and Anti-Drug Antibody Levels for Selected Biologic Agents

Established

- Infertility Related to Cancer Treatment
- Cardiac Rehabilitation, Outpatient
- Elemental Formulas
- Prostate Cancer Early Detection: Biomarkers Prior to Biopsy

Medical Policy Updates

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.

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

New and updated TurningPoint medical policies for musculoskeletal and pain management procedures

Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Healthcare Solutions LLC are adding and updating TurningPoint medical policies for musculoskeletal and pain management procedures for dates of service on or after Oct. 1, 2023.

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

Medicare Advantage members in crisis to get new options for behavioral health care treatment

Starting Jan. 1, 2024, our Medicare Advantage members (Medicare Plus Blue℠ and BCN Advantage℠) will have some new options for receiving help if they're having a behavioral health crisis, as part of our crisis services program.

"These options can be used in place of going to an emergency room in an effort to hasten access to behavioral health-focused care," said Dr. William Beecroft, medical director of behavioral health for Blue Cross Blue Shield of Michigan.

Blue Cross and Blue Care Network commercial plans began offering this program in October 2021.

Care options include:

- Psychiatric urgent care
- Mobile crisis services
- On-site crisis stabilization services
- Residential crisis treatment

Several facilities in Michigan currently offer these services as part of this program, with additional facilities expected to join the program in the future.

See our ***Help in times of crisis*** flyer for details on locations, phone numbers, service areas and care options available at these locations.

In a crisis, members or other individuals — including family members, friends, law enforcement personnel or emergency department staff — can call the number of a crisis location in their service area for guidance. A mobile unit may be deployed to offer assessment and treatment. Walk-ins are also accepted at some locations.

"The goal of such services is to make sure our members get treated at the right place at the right time," Dr. Beecroft said.

About our mobile crisis services

Mobile crisis services include:

- Professional mental health teams in the community who can evaluate the members wherever they are located — even in their homes, school, work or doctor's office
- Face-to-face evaluations, telemedicine or phone evaluations to develop a treatment plan, initiate treatment and, if needed, referral to an appropriate placement for the member

The mobile crisis team may stay involved for two to four weeks after the initial encounter to ensure members are connected to the right level of care for mental health or substance use disorder treatment, and to provide treatment as necessary.

About our on-site crisis stabilization services

On-site crisis stabilization services include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)
- Physical site-based services that are necessary to support the mobile crisis team
  - Includes intake assessment, psychiatric evaluation, crisis intervention and initiation of treatment, such as psychotherapy, medication administration, therapeutic injection, observation and peer support
- Initiating coordinated linkages and "warm handoffs" to the appropriate level of care and community resources

Facilities used for physical site-based services are open 24/7. Members will have access to services from a multidisciplinary staff, including physicians, registered nurses, licensed master social workers, psychologists, clinical supervisors and additional support staff.

As part of the evaluation and treatment process at these facilities, some members may still need psychiatric hospitalization.

We'll keep you informed as additional locations join this program.

Blue Cross and BCN begin using Quartet to help connect members with behavioral health providers

Blue Cross Blue Shield of Michigan and Blue Care Network are now using Quartet, an independent company, to assist our members who are seeking outpatient care for mental health or substance use disorders. This service, which is available at no extra cost to eligible members, is especially useful for people who are having difficulty locating and obtaining timely care from a behavioral health specialist in their area.

Effective July 1, 2023, Quartet began referring eligible members seeking outpatient treatment to behavioral health providers registered on Quartet's online platform, based on the behavioral health providers' clinical specialty and their availability.

Quartet's services are available to the following adult members (18 years of age or older) who reside in Michigan:

- Fully insured Blue Cross commercial members
- Fully insured Blue Care Network commercial members
- All BCN Advantage℠ members
- Select Medicare Plus Blue℠ members

Joining the Quartet online platform

Quartet began reaching out to Blue Cross and BCN participating behavioral health providers in April to assist them in joining the Quartet platform. Participation is voluntary, and providers are still welcome to sign up. Through Quartet, a behavioral health provider can receive referrals, accept new patients, track the patient's progress and access clinical assessments and other resources.

"We hope our behavioral health providers are encouraged to join and will see the value in this tool for both practitioners and patients," said Dr. Amy McKenzie, vice president, Clinical Partnerships and associate chief medical officer for Blue Cross. "We know that some of our members struggle to find the behavioral health care they need, and our relationship with Quartet is designed to help meet their needs."

For more information

- To schedule a demo or sign up to be part of the Quartet platform, visit **quartethealth.com/mental-health-providers** for more information.
- To learn more about Quartet's guidelines and patient referral process, refer to the **Quartet Care Navigation Platform: FAQ for behavioral health providers**, which is also available on the following webpages:
  - ***Blue Cross Behavioral Health*** on **ereferrals.bcbsm.com**. In the section titled *For both Blue Cross commercial and Medicare Plus Blue members*, look under the *General resources* heading.
  - ***BCN Behavioral Health*** on ereferrals.bcbsm.com. Look under the *Other resources* heading.
  - *Secure Provider Resources* on our provider portal (**availity.com**). Click on the *Member Care* tab and then on *Behavioral Health*. Scroll down and look under the *General Resources* heading.
- Check out our **Quartet flyer**, which is available on **ereferrals.bcbsm.com** and the *Behavioral Health* page on the *Provider Resources* site.

Quartet is an independent company contracted by Blue Cross Blue Shield of Michigan to provide behavioral health services for Blue Cross and BCN members.

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

Blue Cross and BCN behavioral health changes coming Jan. 1, 2024

Starting Jan. 1, 2024, Blue Cross and BCN will consolidate the prior authorization and case management functions for behavioral health services, including treatment for autism. This change will affect all members.

See the **cover story** for details.

Pharmacy News

How Blue Cross and BCN are handling authorizations for Makena following FDA announcement

In a **news release** dated April 6, 2023, the U.S. Food & Drug Administration announced it has withdrawn its approval of Makena® (hydroxyprogesterone caproate), HCPCS codes J1726 and J1729. This decision also applies to generic Makena products.

This means that Makena and its generic products are now unapproved and cannot lawfully be distributed in interstate commerce.

For Blue Cross Blue Shield of Michigan and Blue Care Network commercial members, here's how we're handling authorizations for Makena:

- We'll honor prior authorization requests that have already been approved for this medical benefit drug through their end dates.
- Due to the change in approval status from the FDA, we're denying prior authorization requests submitted for dates of service on or after April 6, 2023.

These changes apply to:

- All Blue Cross and BCN commercial members
- All versions of Makena, including compounded and generic versions

We've updated the pertinent drug lists to reflect this change.

Requirements and codes changed for some 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 comprehensive lists of requirements for our members.

In April, May and June of 2023, we added requirements for some medical benefit drugs. These requirements went into effect on various dates.

In addition, some drugs were assigned new HCPCS codes.

Keep reading for the details you need to know.

Changes in requirements

- For **Blue Cross commercial and BCN commercial members**
  We added prior authorization requirements, site-of-care requirements or both as follows:

HCPCS code	Brand name	Generic name	Requirement	
			Prior authorization	Site of care
J3590*	Elfabrio®	pegunigalsidase alfa-iwxj	✓	
J3590*	Omisirge®	omidubicel-onlv	✓	
J3590*	Qalsody™	tofersen	✓	
J3590*	Vyjuvek™	beremagene geperpavec-svdt	✓	

Please see Requirements and codes changed for some medical benefit drugs *continued on Page 24*

Requirements and codes changed for some medical benefit drugs, *continued from Page 23*

- For **Medicare Plus Blue℠ and BCN Advantage℠ members**

  We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name	For dates of service on or after
J3590*	Syfovre™	pegcetacoplan injection	4/3/2023
J9029	Adstiladrin®	nadofaragene firadenovec-vncg	5/1/2023
J3590*	Lamzede®	velmanase alfa	5/1/2023

Code changes

The table below shows HCPCS code changes that were effective April 1, 2023, for the medical benefit drugs we manage.

New HCPCS code	Brand name	Generic name
Q5128	Cimerli™	ranibizumab-eqrn
Q5130	Fylnetra®	pegfilgrastim-pbbk
J1411	Hemgenix®	etranacogene dezaparvovec-drlb
J1449	Rolvedon™	eflapegrastim-xnst
J1747	Spevigo®	spesolimab-sbzo
Q5127	Stimufend®	pegfilgrastim-fpgk
C9149	Tzield™	teplizumab-mzwv
Q5129	Vegzelma®	bevacizumab-adcd
J0218	Xenpozyme™	olipudase alfa-rpcp

Drug lists

For additional details, see the following drug lists:

- For commercial members: **Blue Cross and BCN utilization management medical drug list**
- For Medicare Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

These lists are also available on the following pages of the **ereferrals.bcbsm.com** website:

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

Additional information about these requirements

We communicated these changes previously through provider alerts. Those alerts contain additional details.

You can view the provider alerts on ereferrals.bcbsm.com and on our Provider Resources site, which is accessible through our provider portal (**availity.com**).

Additional information for Blue Cross commercial groups

For Blue Cross commercial groups, authorization requirements apply only to groups that 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.

Reminder

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

*May be assigned a unique code in the future.

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

Pharmacy News

Starting Jan. 1, 2024, all DME codes will be removed from the CareCentrix HIT and AIS program

For dates of service on or after Jan. 1, 2024, the durable medical equipment codes listed in the table below will be removed from the CareCentrix network management program for home infusion therapy and ambulatory infusion suite providers.

HCPCS codes					
B2034	B2035	B2036	B4081	B4082	B4083
B4087	B4102	B4103	B4104	B4105	B4149
B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162	B4185
B4187	B9002	B9998			

This change applies to:

- Blue Cross Blue Shield of Michigan and Blue Care Network commercial members
- Independent home infusion therapy and ambulatory infusion suite providers

Note: Ambulatory infusion suite providers are a subset of ambulatory infusion centers.

These codes are still part of the DME benefit. Providers who participate in the Blue Cross or BCN DME network can bill them in line with existing Blue Cross or BCN billing guidelines.

Prior to Jan. 1, 2024, we'll update the **Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions** document to reflect this change.

Elahere, Imjudo, Tecvayli, Lunsumio to require prior authorization for most members starting Aug. 23

For dates of service on or after Aug. 23, 2023, the following drugs require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members:

- Elahere™ (mirvetuximab soravtansine-gynx), HCPCS code J9063
- Imjudo® (tremelimumab-actl), HCPCS code J9347
- Tecvayli™ (teclistamab-cqyv), HCPCS code J9380
- Lunsumio™ (mosunetuzumab-axgb), HCPCS code J9350

These drugs are covered under the members' medical benefits, not their pharmacy benefits.

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

- Blue Cross Blue Shield of Michigan commercial
  - All fully insured members (group and individual).
  - Members who have coverage through **self-funded groups that have opted in to the Carelon medical oncology program.** (Although UAW Retiree Medical Benefits Trust non-Medicare plans have opted into this program, these requirements may not apply; refer to their medical onolcogy drug list, which is linked below.)
- Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

Submit authorization requests to Carelon using one of the following methods:

- Through the Carelon ProviderPortal, which you can access by doing one of the following:
  - Logging in to our provider portal (**availity.com**), clicking *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space where you'll click the *Carelon ProviderPortal* tile.
  - Logging in directly to the Carelon ProviderPortal at **providerportal.com**.
- By calling the Carelon 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, 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 Benefits 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 pertinent drug lists to reflect the information in this message prior to the effective date.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage authorizations for select services.

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

Clarification: Xgeva continues to require prior authorization through NovoLogix for most commercial members

Xgeva® (denosumab), HCPCS code J0897, continues to require prior authorization for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members. Providers should submit prior authorization requests for these members through the NovoLogix® online tool.

Note: On Dec. 6, 2022, we published a **provider alert** stating that Xgeva would no longer require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®). That change applied only to Medicare Plus Blue℠ and BCN Advantage℠ members, starting Jan. 1, 2023.

How to submit prior authorization requests

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

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the *Applications* tab.

Note: If you need to request access to our provider portal, see the **Register for webtools** webpage on **bcbsm.com**.

Some Blue Cross commercial groups not subject to this requirement

For Blue Cross commercial groups, this prior authorization requirement applies only to groups that 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**.

You can access this list and other information about requesting prior authorization on the following pages of the **ereferrals.bcbsm.com** website:

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

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 and electronic data interchange services.

We're changing prior authorization requirements for some weight loss drugs

Beginning Sept. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will amend prior authorization coverage criteria for the brand-name weight loss medications listed below for commercial members.

- Contrave®
- Saxenda®
- Xenical®
- Qsymia®
- Wegovy®

For certain members, weight loss drugs are excluded under the pharmacy benefit.

Prior authorization and renewal criteria changes

Starting Sept. 1, we'll shorten the initial prior authorization approval duration to four months from 12 months for commercial Blue Cross and BCN members who initiate one of these drug therapies for the first time. The duration of subsequent prior authorization renewals following initial prior authorization approval will remain unchanged and valid for 12 months for members who meet renewal requirements.

We'll also amend the renewal criteria for these weight loss drugs. Health care providers will be required to attest that the member is actively engaged in appropriate lifestyle modifications in conjunction with weight loss therapy for continuation of coverage after the initial prior authorization expires, and for each renewal request thereafter.

For a list of prior authorization and renewal requirements for pharmacy benefit drugs, refer to our prior authorization and step therapy document at **bcbsm.com/rxinfo**.

Reasons for these changes

Weight loss drug therapy is highly effective when used in conjunction with appropriate lifestyle interventions, including a balanced healthy diet and exercise. Providers should follow up with patients at regular intervals after initiating weight loss pharmacotherapy to make sure they're continuing to engage in appropriate lifestyle modifications for optimal weight loss results.

Documentation of appropriate lifestyle modifications

Providers must attest through electronic prior authorization, or ePA, that the patient has provided them with documentation to show that they're participating in appropriate lifestyle modifications. Here are some examples of documentation and lifestyle modifications:

- Patient documentation of lifestyle modifications may include recent food logs, exercise logs or receipts to show engagement in a formal weight loss modification program.
- Appropriate lifestyle modifications may include member participation in a formal lifestyle modification program or participation in an appropriate lifestyle modification treatment plan (healthy diet and exercise) under the supervision of their provider.

Member eligibility

Not all members have weight loss drugs covered under their pharmacy benefit. Providers should determine if members are eligible before prescribing weight loss drug therapy.

Providers can call the Provider Inquiry automated response system at **1-800-344-8525** to verify eligibility for members with Blue Cross or BCN commercial coverage.

Billing Bulletin

How to find Blue Cross and BCN policies related to COVID-19 public health emergency

Since the COVID-19 public health emergency ended on May 11, 2023, there's a reduced need for viewing Blue Cross Blue Shield of Michigan and Blue Care Network's temporary policies for COVID-19. As a result, we're removing most of them from our public website, **bcbsm.com/providers**.

However, we know providers may need to reference these policies when working on claims for dates of service on or before May 11, 2023. Thus, they can still access the temporary policies by following these steps:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click 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*.

COVID-19-related documents for pharmacies

Some COVID-19-related documents for pharmacies are still available on our public website but have moved to a new location. They are:

- **Pharmacies encouraged to join the Blue Cross Vaccine Affiliation Program**
- COVID-19 testing for pharmacies:
  - **For Blue Cross PPO and BCN HMO members**
  - **For Medicare Plus Blue and BCN Advantage members**

Here's the new location where you can find these documents on our public website:

1. Go to **bcbsm.com/providers**.
2. Click the *Resources* tab.
3. To the right of the *Key Forms and Documents* heading, click *View all*.
4. Scroll down to the *Pharmacy services* section.

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

Billing Bulletin

Clinical editing billing tips

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

This issue's tips:

- Genicular nerve blocks
- Diagnosis code reporting reminders

Clinical Editing Billing Tips

Starting Jan. 1, 2024, all DME codes will be removed from the CareCentrix HIT and AIS program

For dates of service on or after Jan. 1, 2024, some durable medical equipment codes will be removed from the CareCentrix network management program for home infusion therapy and ambulatory infusion suite providers.

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

New on-demand training available

Our Lunch & Learn sessions on coding neoplasms and coding diabetes and hypertension have been recorded and posted on the training website.

See the article on **Page 5** for details.

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

We're offering live, 30-minute educational webinars that provide updated information on documentation and coding for common challenging diagnoses.

See the article on **Page 6** for details.

Referral Roundup

BCN Provider *News*

Feedback

More details on Carelon expansion of existing prior authorization program starting Sept. 1

We communicated in the **July-August 2023 issue**, page 25, that for dates of service on or after Sept. 1, 2023, additional services will require prior authorization by Carelon Medical Benefits Management (formerly known as AIM Specialty Health®).

The codes that Carelon will begin managing on Sept. 1 can be seen in the updated document titled **Procedures that require prior authorization by Carelon: Cardiology, radiation oncology, radiology (high technology) and sleep studies (in lab)**.

In the document, look for the codes highlighted in blue:

- For both Blue Cross and BCN commercial members, additional cardiology and advanced imaging services will require prior authorization.
- For Blue Cross commercial members, additional sleep study services will require prior authorization.
- For BCN commercial members, Carelon will start managing in-lab sleep studies.

By Aug. 14, the Carelon ProviderPortal® and the Carelon call center will be ready to accept prior authorization requests for these additional services.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

Referral Roundup

Changes for in-lab sleep studies to start Oct. 9

Prior authorization requirements for in-lab sleep studies will change for dates of service on or after Oct. 9, 2023.

For dates of service on or after Oct. 9

- For Medicare Plus Blue℠ PPO members, prior authorization won't be required for in-lab sleep studies.
- For BCN Advantage℠ members, prior authorization won't be required for in-lab sleep studies. However, if the provider is out of network for the member's plan, then prior authorization will be required.

For dates of service prior to Oct. 9

Continue to submit prior authorization requests as you do now:

- For Medicare Plus Blue members, submit prior authorization requests to Carelon Medical Benefits Management through the **Carelon ProviderPortal**.

  Additional options for submitting requests are outlined on the Blue Cross **Carelon-Managed Procedures** webpage at **ereferrals.bcbsm.com**.

- For BCN Advantage members, submit prior authorization requests to BCN's Utilization Management team through the e-referral system.

  You must complete the **sleep study questionnaire** in the e-referral system.

Additional information

Prior to Oct. 9, we'll update several documents to reflect these changes, including:

- **Procedures that require prior authorization by Carelon: Cardiology, radiation oncology, radiology (high technology) and sleep studies (in lab)**
- **BCN referral and authorization requirements for Michigan providers**

Carelon Medical Benefits Management (formerly known as 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.

Referral Roundup

Submit prior authorization requests for non-emergency air ambulance flights through the Alacura PreAuth Portal

Prior to each flight, Michigan and non-Michigan providers must submit a prior authorization request for non-emergency air ambulance services. This requirement applies to Blue Cross Blue Shield of Michigan commercial and Blue Care Network commercial members.

Due to Michigan's prior authorization law requirements, providers must submit these requests to Alacura Medical Transport Management electronically.

Submit requests using the web form on the Alacura PreAuth Portal. To learn how to access the web form and for detailed information about completing the form, see the document titled **Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers**.

If you're experiencing temporary technological problems that prevent you from accessing the Alacura PreAuth Portal, you can submit requests by calling Alacura or by faxing the *Air ambulance flight information (non-emergency)* form to Alacura. You can find information about these alternate submission methods in the document linked above.

You can access the overview document and the form discussed above from the **Blue Cross Authorization Requirements & Criteria** page or the **BCN Authorization Requirements & Criteria** page on the **ereferrals.bcbsm.com** website.

Alacura Medical Transport Management is an independent company that manages the authorization of non-emergency flights for Blue Cross Blue Shield of Michigan and Blue Care Network members who have commercial plans.

New and updated TurningPoint medical policies for musculoskeletal and pain management procedures

Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Healthcare Solutions LLC are adding and updating TurningPoint medical policies for musculoskeletal and pain management procedures. These policies apply to dates of service on or after Oct. 1, 2023.

The new and updated TurningPoint medical policies will be available in the TurningPoint provider portal on Oct. 1, 2023.

To see a list of the new TurningPoint medical policies and details about updates to existing TurningPoint medical policies, see our **July 27, 2023, provider alert**.

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 commercial LTACH requests, submit information about three SNFs to avoid delays

As a reminder, for prior authorization requests for admissions to long-term acute care hospitals, or LTACHs, you are required to include information about three skilled nursing facilities, or SNFs, you have contacted. These must be SNFs that you believe may be able to provide care for the member but have indicated they can't provide the level of care the member requires.

This applies to LTACH placement requests for Blue Cross and BCN commercial members.

If the information that's required about the three SNFs isn't included when you submit the prior authorization request, the request is considered incomplete and can't be processed. We'll reach out to you and ask that you resubmit the request when the information is available. This delays the processing of the request.

Here's the information we need about the three SNFs:

- Name of the SNF
- Phone number of the SNF
- Name of the person you talked to at the SNF
- Reason the SNF gave for not accepting the member

Be aware that:

- The three SNFs must be contracted with Blue Cross or BCN and located within 75 miles of the facility in which the member is currently a patient.
- Two of the three SNFs must be facilities that can accommodate members who need higher levels of care.

You can read more about these and other requirements in the document **Blue Cross and BCN Local Rules for 2023 for post-acute care: Modifications of InterQual® criteria**.

You can access this document at **ereferrals.bcbsm.com**, on these webpages:

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

Questionnaire updates in the e-referral system

In June, we updated questionnaires in the e-referral system. 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.

Updated questionnaires

We updated the following questionnaires on the date specified below:

Questionnaire	Opens for	Updates	Release date
Blepharoplasty	• Medicare Plus Blue℠ • BCN commercial • BCN Advantage℠	• Updated a question • Added two questions	6/25/2023
Left atrial appendage closure	BCN commercial	Added a question	6/11/2023
Left atrial appendage closure	• Medicare Plus Blue • BCN Advantage	• Updated a few questions • Added a question	6/11/2023
Septoplasty	• Medicare Plus Blue • BCN commercial • BCN Advantage	This questionnaire no longer opens for pediatric members	6/25/2023

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time. To access them, go to **ereferrals.bcbsm.com** and:

- 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**. Scroll down and look under the "Authorization criteria and preview questionnaires – Medicare Plus Blue" heading.

Authorization criteria and medical policies

The Authorization Requirements & Criteria pages explain how to access the pertinent authorization criteria and medical policies.

Use new mailing address for provider appeals of some utilization management decisions

A mailing address for submitting provider appeals of some utilization management decisions has changed as shown below.

Previous address	New address
Utilization Management — Provider Appeals Mail Code C336 Blue Cross Blue Shield of Michigan and Blue Care Network P.O. Box 5043 Southfield, MI 48076-5043	Utilization Management — Provider Appeals Mail Code 0520 Blue Cross Blue Shield of Michigan and Blue Care Network 600 E. Lafayette Blvd. Detroit, MI 48226-2998

We updated the denial letters to include the new address.

Be sure to follow the instructions in the denial letters to help ensure that your appeal arrives at the appropriate location within the time frame allowed.

How Blue Cross and BCN are handling authorizations for Makena following FDA announcement

The U.S. Food & Drug Administration announced it has withdrawn its approval of Makena® (hydroxyprogesterone caproate), HCPCS codes J1726 and J1729. This decision also applies to generic Makena products.

See the article on **Page 22** for details.

Requirements and codes changed for some 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 comprehensive lists of requirements for our members.

In April, May and June of 2023, we added requirements for some medical benefit drugs.

See the article on **Page 23** for details.

Elahere, Imjudo, Tecvayli, Lunsumio to require prior authorization for most members starting Aug. 23

For dates of service on or after Aug. 23, 2023, the following drugs require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members:

- Elahere™ (mirvetuximab soravtansine-gynx), HCPCS code J9063
- Imjudo® (tremelimumab-actl), HCPCS code J9347
- Tecvayli™ (teclistamab-cqyv), HCPCS code J9380
- Lunsumio™ (mosunetuzumab-axgb), HCPCS code J9350

These drugs are covered under the members' medical benefits, not their pharmacy benefits.

See the article on **Page 26** for details.

Clarification: Xgeva continues to require prior authorization through NovoLogix for most commercial members

Xgeva® (denosumab), HCPCS code J0897, continues to require prior authorization for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members. Providers should submit prior authorization requests for these members through the NovoLogix® online tool.

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

We're changing prior authorization requirements for some weight loss drugs

Beginning Sept. 1, 2023, Blue Cross Blue Shield of Michigan and Blue Care Network will amend prior authorization coverage criteria for the brand-name weight loss medications listed below for commercial members.

- Contrave®
- Qsymia®
- Saxenda®
- Wegovy®
- Xenical®

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

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.

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

Referral Roundup

BCN staff available to our members for utilization management issues

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

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

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.

See the article on **Page 3** for details and to learn how to obtain a copy of utilization management criteria.

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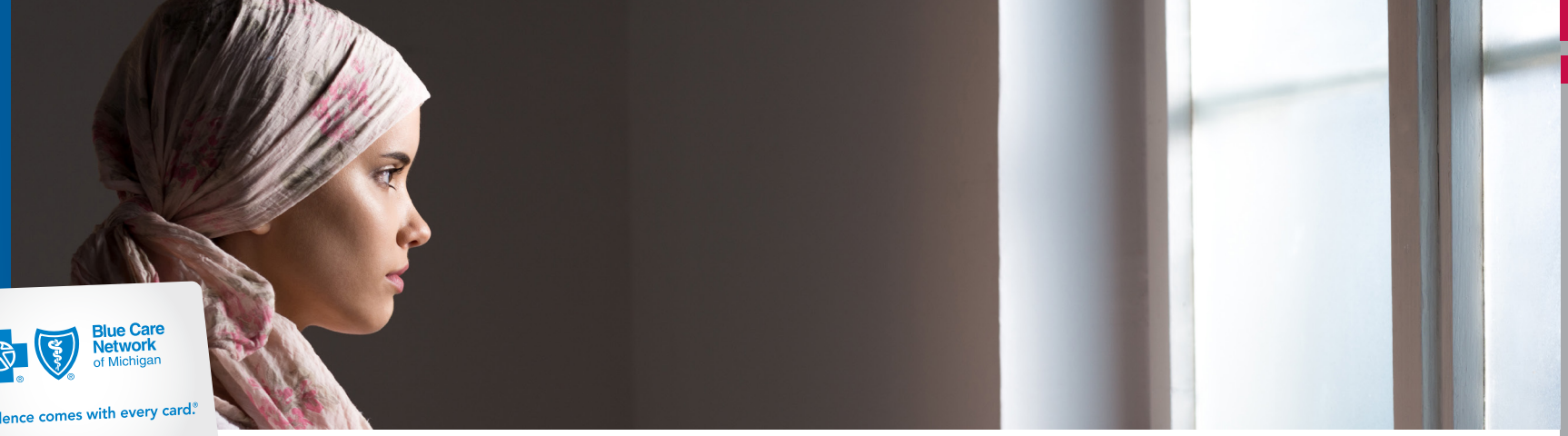
BCN Provider News



Starting Jan. 1, new cancer support program will be available for some commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network are working with OncoHealth® to provide a cancer support program (Iris by OncoHealth) for adult members ages 18 and older who have a cancer diagnosis or who are cancer survivors.

Starting Jan. 1, 2024, this program will help members navigate the emotional, physical and financial challenges caused by cancer diagnosis and treatment. It also aims to lower the burden on health care providers and complement — not replace or interfere with — the care they provide. It's meant to provide supplemental support and education between regularly scheduled, in-person appointments.

Iris by OncoHealth will be available to:

- Members who have coverage through Blue Cross and BCN commercial fully insured groups
- Commercial members who have individual coverage
- Members who have coverage through self-funded commercial groups that purchase the program

There will be no cost to eligible members. With permission from the member, it will also be available to their caregivers.

Through the Iris mobile app or by phone, the program will include access to:

- **24/7 support from oncology nurses** — Members can discuss symptoms and side effects with oncology nurses. The Iris nurses report new or worsening symptoms to the member's primary oncology team by fax or phone. The Iris nursing team is supported by medical oncologists and advanced practice providers who are available for case escalation.

  Note: The Iris nurses use OncoHealth Medical Group's symptom management pathways to help members manage symptoms. The pathways are based on standards of care established by the National

Feedback | Subscribe

Inside this issue…

Comprehensive Cancer Network, the American Society of Clinical Oncology and the Oncology Nursing Society, adapted for use in virtual care.

Symptom management pathways won't include prescription medications, but may include over-the-counter medications.

- **Oncology-specific mental health support** — Members can schedule virtual care appointments with licensed therapists. The Iris therapists offer members support for cancer-specific concerns, including adjusting to illness, coping with anxiety, depression and uncertainty, and communicating with their care teams. Members are often able to meet with a therapist within 24 to 48 hours of scheduling an appointment.
- **Registered dietitian nutritionists with cancer expertise** — The Iris dietitians offer personalized support to address high-impact nutritional symptoms and provide diagnosis-specific guidance related to food and nutrition. As of July 2023: Prior authorizations for autism treatment services are approved for shortened times — that is, for less than the typical six-month time period.
- **Peer mentors** — A trained team of cancer patients, caregivers and survivors are available to support and advise members based on their own experiences navigating a cancer diagnosis.
- **Customized educational information** — This includes a library of clinically approved videos, articles and other self-guided content curated for each member.
- **A symptom tracker** — Members can report symptoms and side effects through the tracker in the mobile app. Iris nurses remotely monitor the information members enter, which enables them to intervene early when necessary.
- **Advance care planning assistance**
- **Navigation to financial and community resources** — These resources reduce barriers to care.
- **Interpreters** — If English isn't the member's first language, interpreters are available.

To learn more, view this **Iris by OncoHealth video** or go to **IrisOncology.com**.

OncoHealth is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing cancer support services.

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Blue Care Network is making minor changes to group and individual health plans in 2024

Starting on Jan. 1, 2024, Blue Care Network will be modifying some of the health plans we offer to both groups and individuals. Here's a quick summary of what's changing.

Group health plans

- Out-of-pocket maximums are increasing for some plans; for individual plans from $9,100 in 2023 to $9,450, and for family plans from $18,200 in 2023 to $18,900. A plan can have a lower out-of-pocket maximum so long as it's not exceeding the above annual limit.
- The health savings account IRS limits are increasing for deductibles and out-of-pocket maximums.
- About 35% of small-group plans have changes in member cost sharing.
- For large groups with high-deductible health plans or health savings account plans, we're adding an option to remove the deductible from medical and pharmacy expanded preventive services to make it easier to have covered services prior to meeting the plan deductible.

Individual health plans

- We're decreasing the number of health plans available for purchase by individuals from 48 to 43 plans in 2024. The number of HMO health plans available for purchase by individuals is decreasing from 38 to 33 in 2024.
- All members in a discontinued health plan will be notified by Nov. 1, 2023.
- The deductible and out-of-pocket maximums are changing for a majority of our plans, and some office visit copays are changing.

Check eligibility and benefits

Remember to check member eligibility and benefits at each visit to see that the coverage is in effect and review the member's coverage for the services you provide. You can check eligibility and benefits through:

- Our provider portal, using the Eligibility and Benefits Inquiry application
- Provider Inquiry, with automated response available 24 hours a day, and representatives available 8 a.m. to 5 p.m., Monday through Friday
  - Professional providers call 1-800-344-8525
  - Hospital and facilities call 1-800-249-5103
  - Vision and hearing providers call 1-800-482-4047
- HIPAA 270/271 electronic standard transaction

Network Operations

Newly enrolled PAs and NPs are required to identify their work settings to help avoid payment issues

What you need to know

This requirement applies to newly enrolled PAs and NPs only. Work setting information for PAs and NPs enrolled prior to Nov. 10 will be updated automatically — there is no action required.

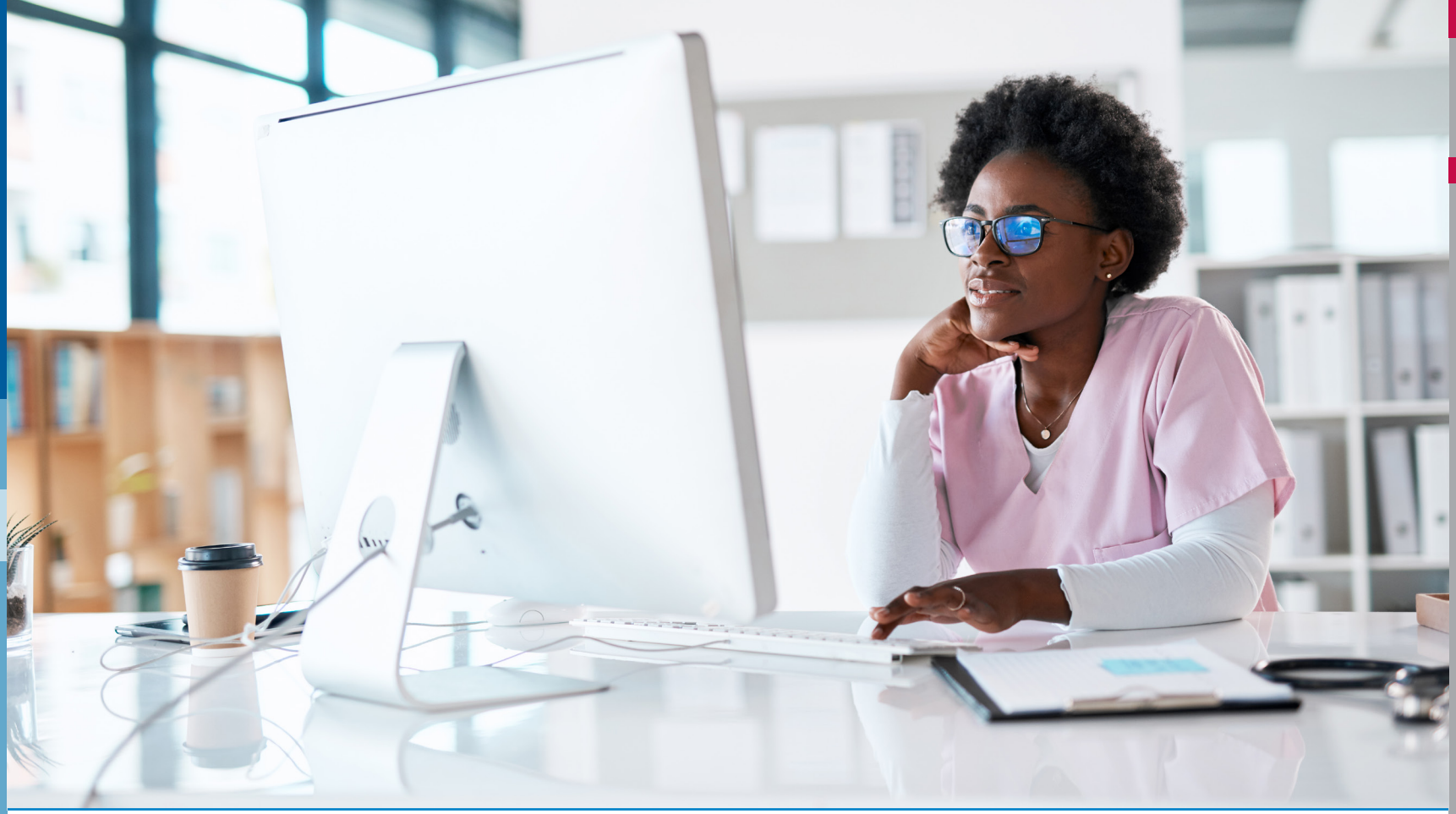
Starting Nov. 10, 2023, newly enrolled physician assistants and nurse practitioners will be required to identify their work settings (primary care or specialty care) on our provider enrollment and change forms. This information is necessary to help ensure that withholds can be accurately applied and payment issues can be resolved for PAs and NPs covering for physician specialists or primary care physicians.

The following provider enrollment and change forms have been updated to include work setting:

- *Allied Practitioner Enrollment Form*
- *Allied Practitioner Change Form*
- *New Group Enrollment Form*
- *Group Change Form*

Provider enrollment and change forms can be found in the Enrollment section at **bcbsm.com**.

Network Operations



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

As a reminder, we're offering live, 30-minute educational webinars that provide updated information on documentation and coding for common challenging diagnoses. Webinars also include an opportunity to ask questions.

Here's our upcoming schedule and tentative topics for the webinars. Each session starts at noon Eastern time. Log in to the provider training website to register for sessions that work with your schedule.

Session date	Topic
Oct. 18	ICD-10-CM updates and changes for 2024
Nov. 15	Coding chronic kidney disease and rheumatoid arthritis
Dec. 13	CPT coding scenarios for 2024

Network Operations

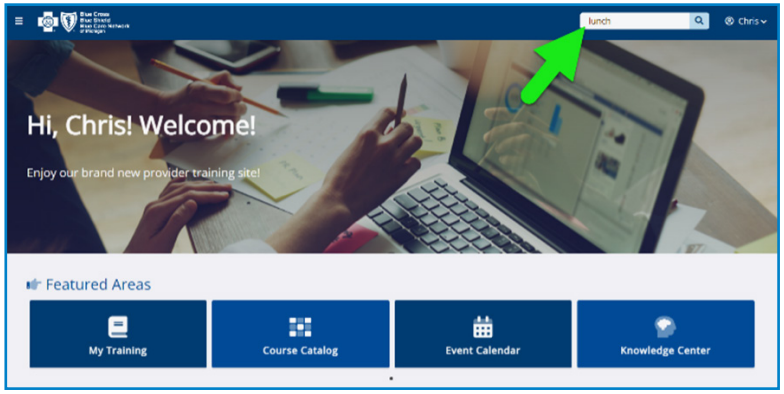
If you haven't already registered for the provider training website, follow these steps:

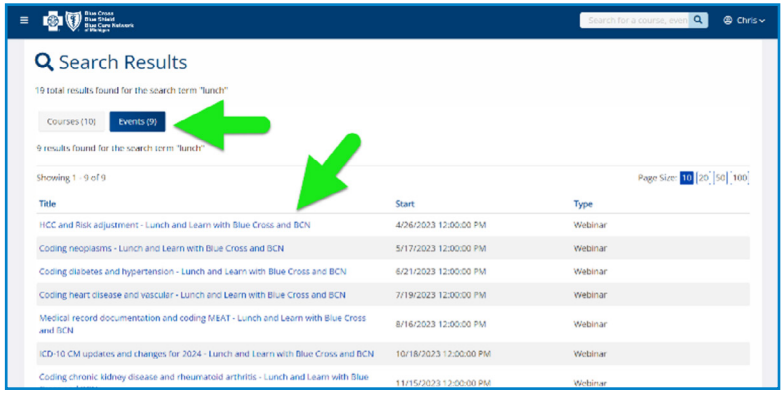
- **Click here to register**.
- Complete the registration. We recommend using the same email you use to communicate with Blue Cross Blue Shield of Michigan for other needs. This will become your login ID.

Locating a session

Click here if you are already registered for the provider training website. On the provider training website, look in the *Event Calendar* or use the search feature using the keyword "lunch" to quickly locate all 2023 sessions.

See the screenshots below for more details.





Previous sessions

You can also listen to previously recorded sessions. Check out the following:

Date	Topic
April 26	HCC and risk adjustment coding scenarios
May 17	Coding neoplasms
June 21	Coding diabetes and hypertension
July 19	Coding heart disease and vascular
Aug 16	Medical record documentation and MEAT
Sept. 20	Coding Tips for COPD and asthma

For more information

If you have any questions about the sessions, contact April Boyce at **aboyce@bcbsm.com**. If you have questions about a session or website registration, email **ProviderTraining@bcbsm.com**.

Resources, on-demand courses available on our training website

Action Items

We encourage you to use our **provider training website** to take courses and learn about topics relevant to your work.

Take advantage of the training resources we offer to health care providers and their staff. Resources include on-demand courses designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

See the information below to find out about some of the learning opportunities we launched earlier this year that we think you'll find worthwhile.

Blue Cross Personalized Medicine℠ presentations: We hosted a series of webinars discussing this new program, which is based on pharmacogenomics, a subgroup of precision medicine. The presentations are specific to primary care physicians, behavioral health providers, cardiologists and oncologists. Search "personalized" on the training website to quickly locate the four presentations.

CMS Star measures overview for 2023: This course is an overview of HEDIS® quality measures that are also Medicare Star Ratings measures. Updated for 2023, the course has a new section on the CAHPS® survey, tips for closing gaps in care, clarifications on quality measure requirements and assistance with coding and documentation. You can earn continuing education credits for completing these courses. Search "star" to locate the series.

HEDIS® measures scenarios for 2023: This course shows you how to close quality gaps using the HEDIS® tip sheets. Learn the tips and tricks through a series of scenarios where you'll help figure out why an office is seeing gaps in specific measures. The course has been updated for 2023 and is also eligible for continuing education credits. Search "HEDIS" to locate the course.

To log in to the provider training site, **click here**.

To request access to our training site:

1. Visit the **registration page** and provide the requested information. We recommend using the same email you use to communicate with Blue Cross for provider-related needs. This will become your login ID.
2. Click on *Register*, and follow the prompts to log in.

If you need assistance registering or navigating the site, contact **providertraining@bcbsm.com**.

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

New Patient Experience webinar series

We are excited to announce an upcoming **Patient Experience** webinar series, "Combatting Burnout in the Healthcare Setting." This five-part series will provide practical tips to help healthcare professionals manage their own stress and burnout. Visit the Patient Experience website for more information and to register. Also be sure to check out the On-Demand Webinars page on the website to register to view our Consumer Assessment of Healthcare Providers and Systems (CAHPS) best practices webinars.

New mailing address for BCN Appeals and Grievance Unit

Blue Care Network's Appeals and Grievance Unit has a new mailing address.

Previous address	New address
Appeals and Grievance Unit Blue Care Network P.O. Box 284 Southfield, MI 48086-5043	Appeals and Grievance Unit Blue Care Network P.O. Box 44200 Detroit, MI 48244-0191

The fax number for the unit, 1-866-522-7345, has not changed.

We've updated the *BCN Provider Manual* to include the new address. You can find the new address — and more information about submitting appeals and grievances for BCN commercial and BCN Advantage℠ members — in these chapters of the manual:

- Member Rights and Responsibilities chapter
- **BCN Advantage chapter**

To access the *BCN Provider Manual*:

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

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

Free mail-order COVID-19 tests sent directly to patients

Due to an increase in demand for COVID-19 testing, the federal government is restarting a program for each U.S. household to order four free COVID-19 rapid tests for mail delivery. These tests can be ordered through **COVIDtests.gov**.

Medicare Plus Blue, BCN Advantage offer additional benefits for 2024

Medicare Plus Blue℠ and BCN Advantage℠ added three enhanced benefits to their comprehensive Medicare Advantage plans for the 2024 plan year. Beginning Jan. 1, 2024, members can capitalize on the following:

- Ambulance services without transport
- Enhanced annual wellness visit
- Mobile crisis and crisis stabilization for behavioral health (available for members who reside in select counties)

Note: Please check patient's eligibility and benefits in our provider portal (availity.com) to verify coverage for these new benefits.

New 2024 enhanced benefits explained

Ambulance services without transport: Currently, if a member or another person calls for an ambulance for a member's health emergency, and the member isn't transported, the service isn't covered. Beginning Jan. 1, 2024, if the ambulance providers are able to stabilize the member at the current location without transporting to a facility, the plan covers the services with the applicable cost sharing. This service isn't covered outside of the U.S. or its territories.

Enhanced annual wellness visit: After having Medicare Part B for longer than 12 months, members can get an annual wellness visit every 12 months to develop or update a personalized prevention plan based on their current health and risk factors. They can get the enhanced annual wellness visit anytime throughout a calendar year, regardless of the date of the previous year's visit. No cost sharing applies.

Mobile crisis and crisis stabilization for behavioral health: This benefit offers improved care for people experiencing a behavioral health crisis. Services include mobile crisis intervention by eligible providers through telehealth or face to face, onsite services and crisis stabilization. Members can be treated in their homes or other locations and at participating outpatient psychiatric centers available in certain counties in Michigan. Cost sharing applies. For more information on crisis care services and locations, visit our crisis care webpage on our website.

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

BCN Advantage

Update on high-intensity, in-home care program through Landmark

Blue Cross Blue Shield of Michigan and Blue Care Network launched the Landmark high-intensity, in-home care program in late 2021 for eligible members in Southeast Michigan with coverage through an employer group. The program was expanded in phases and, starting in January 2023, it's now available to all eligible Medicare Plus Blue℠ and BCN Advantage℠ members who reside in Michigan's Lower Peninsula.

Blue Cross and BCN offer this program as a benefit for our most at-risk members. This additional, in-home support is also something employer groups have requested to help improve quality of life and health outcomes.

To be eligible for the Landmark program, members must have multiple chronic conditions and take a high number of prescription medications. Currently, approximately 15% of Blue Cross and BCN's Medicare Advantage members are eligible.

Using a physician-led, interdisciplinary team, the Landmark program complements office-based primary care by:

- Collaborating and coordinating with each member's primary care provider, using the primary care provider's preferred method of communication
- Supporting frail, elderly patients who want help managing their conditions through in-home care
- Delivering additional support, including medical, behavioral and urgent care; medication management; and 24/7 nurse triage when a member is unable to reach their primary care provider

The Landmark program provides supplemental support and reinforces the primary care provider's plan of care for chronic condition management. It doesn't replace a member's primary care provider, and members don't become attributed or assigned to Landmark.

Note: Because the Landmark program is part of members' benefits, eligible members can choose whether they want to participate.

Program outcomes

We're beginning to see the benefits of the Landmark program on this vulnerable member population.

Early data from the initial phase of the program has shown the following for engaged members:

- An increase in primary care provider visits
- A decrease in acute inpatient utilization after a period of time in the program
- High member satisfaction, with 96% rating it as excellent, very good or good

Landmark has built collaborative relationships with a number of physician organizations and is willing to adapt processes and communication methods to best meet the unique needs of each physician organization.

At a recent Physician Group Incentive Program, or PGIP, meeting, Sparrow Care Network shared details of how they're working with Landmark to build a successful collaboration, despite initial concerns from Sparrow providers about the program. The working relationship is being customized to fit into Sparrow's overall Population Health Service Organization and requires engagement from clinical and operational teams from both organizations. Sparrow Care Managers also play a significant role in ensuring communication flows appropriately in both directions. Sparrow has expressed appreciation for Landmark's flexibility and responsiveness, and continues to collaborate on achieving best care outcomes for patients.

What members are saying about the Landmark program

Here are just a few quotes from Blue Cross and BCN members who are engaged in the Landmark program:

"I was in need of some help. My Dr. wasn't available. Erica [nurse practitioner] arrived within a few hours. Erica was very friendly and professional. I am grateful for her help."

"Wonderful experience. Very professional, but very caring. Very nice to have medical service at home."

"The nurses have been very good about responding to me when I get sick or fall. I'm grateful they're included in my insurance plan."

"My father received excellent and immediate care in his home when his cold became more serious with shortness of breath, fever and productive cough. I was able to talk with the clinician by phone during the visit and all our concerns were addressed. Follow-up care was also excellent."

"Great program for keeping my health at its best."

How to learn more

To learn more about our program with Landmark, see the High-intensity in-home care program: **Frequently asked questions for providers document**.

If you have questions about the program, email the Blue Cross Care Delivery Solutions team at **CareDeliverySolutionsProgramMtg@bcbsm.com**.

To coordinate directly with Landmark about patient care, call 313-241-5242.

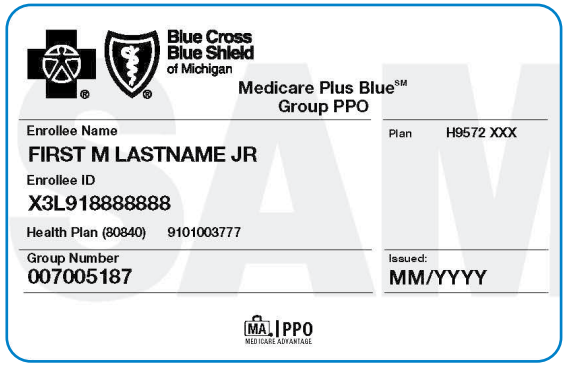
Landmark Health L.L.C is an independent company that provides in-home care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

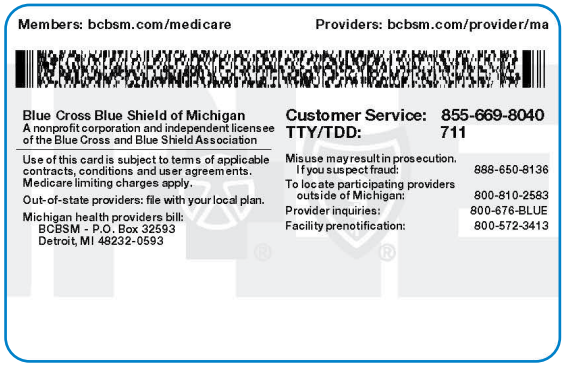
University of Michigan retirees join our Medicare Advantage plans

University of Michigan retirees will become members of our Medicare Advantage plans and will be able to choose either a Medicare Plus Blue℠ or BCN Advantage℠ plan, effective Jan. 1, 2024. These plans provide coverage for medical and surgical benefits (Part C). Magellan administers their prescription drug benefits (Part D).

How do I recognize a University of Michigan Medicare Advantage member?

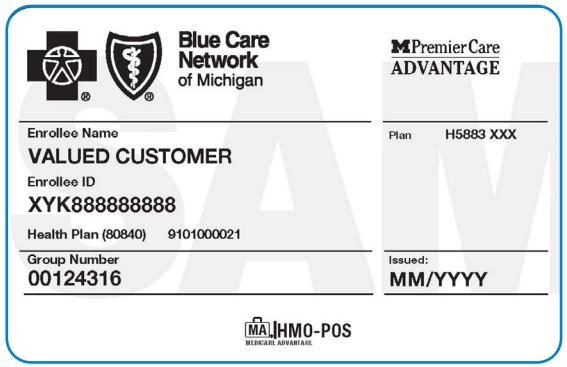
For the PPO plan, University of Michigan Medicare Plus Blue members have Blue Cross Blue Shield of Michigan identification cards with the Medicare Plus Blue Group PPO logo near the top center. They use group number 007005187 and have the alphanumeric prefix X3L. The PPO logo shows that the member is enrolled in a preferred provider organization plan.

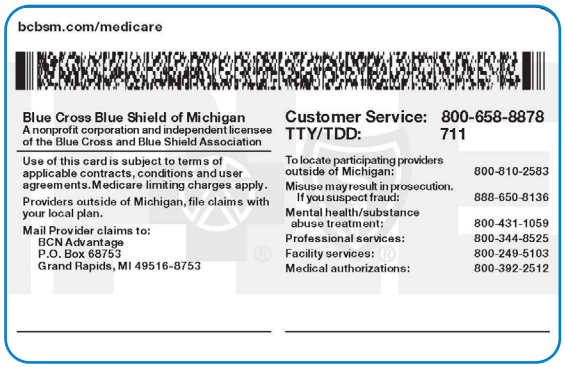




For the HMO-POS plan, the University of Michigan BCN Advantage plan is called U-M PremierCare Advantage, which will be displayed at the top right. The ID card will say Blue Care Network of Michigan at the top left and will show group number 00124316 and have the alpha prefix XYK before the enrollee ID number. The HMO-POS logo next to the MA suitcase image at the bottom center shows that members have a point-of-service option, which means they can use providers outside the plan's network for an additional cost.

Note: Providers should verify eligibility and coverage at every visit. To verify eligibility and check coverage, log in to our provider portal on Availity Essentials at **availity.com**.





Enhanced Benefits

University of Michigan Medicare Advantage members have some additional enhanced benefits not offered to other groups. Visit the **Medicare Plus Blue PPO Enhanced Benefits Policies webpage** or the **BCN Advantage Enhanced Benefits Policies webpage** and search for University of Michigan MA for more information.

What do I need to know about prior authorization for University of Michigan Medicare Advantage members?

Like our other Medicare Advantage plans, University of Michigan Medicare Advantage benefits require prior authorization for all acute inpatient admissions, specified high-tech radiology services, and for skilled nursing, long-term acute care, and inpatient rehabilitation admissions. For prior authorization requirements, refer to the appropriate provider manual listed below:

- ***Medicare Plus Blue PPO Provider Manual***
- ***BCN Provider Manual – BCN Advantage chapter***

Here are some other articles in this issue that may be of interest

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

- Artificial pancreas device systems
- Bone marrow transplant — hematopoietic cell transplantation for non-Hodgkin lymphomas
- Cochlear implant
- Genetic testing-assays of genetic expression in tumor tissue as a technique to help guide decision-making in patients with breast cancer
- Genetic testing — next generation sequencing for assessment of measurable residual (for example, ClonoSEQ) in hematological malignancies
- Genetic testing-whole exome and whole genome sequencing for diagnosis of genetic disorders
- Leadless cardiac pacemaker
- Lung and lobar lung transplant
- Procalcitonin testing (PCT)
- Prostatic urethral lift procedure for the treatment of BPH
- Skin and tissue substitutes

Noncovered services

- Cryoablation, radiofrequency ablation, and laser ablation for treatment of chronic rhinitis

Established

- Autism spectrum disorder services
- Intraoperative neurophysiologic monitoring
- Reconstructive breast surgery/management of breast implants

Medical Policy Updates

Here are some other articles in this issue that may be of interest

- *Starting Jan. 1, new cancer support program will be available for some commercial members,* **Page 1**
- *Reminder: Resources, on-demand courses available on our training website,* **Page 7**
- *Medicare Plus Blue, BCN Advantage offer additional benefits for 2024,* **Page 9**
- *Update on high-intensity, in-home care program through Landmark,* **Page 10**
- *Update: New and updated TurningPoint medical policies for musculoskeletal and pain management procedures,* **Page 41**

More information about the Blue Cross and BCN behavioral health changes coming Jan. 1, 2024

We communicated in ***The Record*** and ***BCN Provider News*** that starting Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will consolidate the prior authorization and case management functions for behavioral health services, including treatment for autism.

This will affect members covered by Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ plans, except those in certain employer groups. Refer to the **Mental Health and Substance Use Disorder Carve-Out List**.

The programs are called:

- Blue Cross Behavioral Health℠, which will manage prior authorizations for behavioral health services, including treatment for autism
- Blue Cross Coordinated Care℠, which will handle behavioral health case management

These programs will align and standardize prior authorization and case management functions for Blue Cross and BCN members. We expect this consistency across lines of business to simplify processes for providers.

Consistent processes

The main benefit for providers is consistency across all lines of business. For example, for dates of service on or after Jan. 1, 2024:

- You'll use a new provider portal to submit prior authorization requests for all affected Blue Cross and BCN members.
- For autism treatment services, we'll be revising the requirement to obtain an evaluation through an approved autism evaluation center. Watch for future communications on this topic.

FAQ document

We've published the **Blue Cross Behavioral Health: Frequently asked questions** for providers document, which contains many details you'll need to know.

In the FAQ document, you'll find important information that will help you navigate this change, including how to submit requests for prior authorization, continued stay reviews and appeals for all dates of service.

We'll update the FAQ document with additional information as it becomes available.

Behavioral Health

Change for Blue Cross commercial prior authorization requests

Important! Starting Jan. 1, 2024, New Directions, now known as Lucet, won't handle requests for Blue Cross commercial members with dates of service on or after Jan. 1, 2024.

They also won't handle requests related to dates of service before Jan. 1, 2024. This is a correction to information previously published.

For Blue Cross commercial members, submit requests for prior authorization, continued stay reviews and appeals related to dates of service before Jan. 1, 2024, using one of these methods:

- Email: **BHStrategyAppealsandRetrospectiveRequests@bcbsm.com**
- Call: 313-225-0329

When you email or call, provide:

- Your name and a contact phone number for you
- The member's name and contract number
- The date of service you're inquiring about
- A brief description of what you're requesting (for example, prior authorization, continued stay review or appeal)

Medical necessity criteria

For dates of service on or after Jan. 1, 2024, Blue Cross Behavioral Health will use the following to make determinations on prior authorization requests:

- Level of Care Utilization System, or LOCUS®, criteria
- Child and Adolescent Level of Care Utilization System, or CALOCUS®, criteria
- Early Childhood Services Intensity Instrument, or ECSII, criteria
- The ASAM Criteria®, from the American Society of Addiction Medicine
- Blue Cross and BCN medical policy for transcranial magnetic stimulation

Later in 2023, you'll be able to access these criteria on our **Services That Need Prior Authorization** webpage at **bcbsm.com**.

Appeals process

Starting in 2024, the addresses will change for submitting appeals of prior authorization requests that aren't approved. Refer to the determination letters for the addresses.

Training

We'll offer training for providers to learn how to access and use the new provider portal to submit prior authorization requests. Watch for more information.

Behavioral Health

Learn about the 7 myths about suicide

Suicide is a public health crisis, with one death from suicide every 11 minutes in the United States, according to 2021 data from the Centers for Disease Control and Prevention.

William Beecroft, M.D., medical director of behavioral health for Blue Cross Blue Shield of Michigan and Blue Care Network, recently shared his thoughts on suicide. To learn about suicide warning signs, myths and crisis care options, read ***7 myths about suicide can prevent people from getting the help they need*** in the Sept.-Oct. 2023 issue of *Hospital and Physician Update*.

Here's another article in this issue that may be of interest

- *Medicare Plus Blue, BCN Advantage offer additional benefits for 2024,* **Page 9**

Blue Cross, BCN 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 have added the following vaccines to our list of vaccines covered under the pharmacy benefit:

Vaccines	Common name and abbreviation	Effective date
Arexvy™	Respiratory syncytial virus, or RSV	July 17, 2023
Abrysvo™		
Pfizer COVID-19 Vaccine (2023-2024), 6 months through 4 years old	COVID-19	Sept. 15, 2023
Pfizer COVID-19 Vaccine (2023-2024), 5 through 11 years old		
Comirnaty, Pfizer COVID-19 Vaccine (2023-2024)		
Spikevax, Moderna COVID-19 Vaccine (2023-2024)		
Novavax COVID-19 vaccine (2023-2024)		

Following are 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.

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

Vaccines that are covered and have no age requirement	
Vaccine	**Common name and abbreviation**
• Dengvaxia®	Dengue vaccine — DEN4CYD
• Daptacel® • Infanrix®	Diphtheria, tetanus, and acellular pertussis vaccine — DTaP
• Diphtheria and tetanus toxoids	Diphtheria, tetanus vaccine — DT
• Kinrix® • Quadracel®	DTap and inactivated poliovirus vaccine — DTaP-IPV
• Pediarix®	DTaP, hepatitis B, and inactivated poliovirus vaccine — DTaP-HepB-IPV
• Vaxelis®	DTaP, inactivated poliovirus, Haemophilus influenzae type b, and hepatitis B vaccine — DTaP-IPV-Hib-HepB
• ActHIB® • Hiberix® • PedvaxHIB®	Haemophilus influenzae type b vaccine — Hib
• Havrix® • Vaqta®	Hepatitis A — HepA
• Engerix-B® • Heplisav-B® • PreHevbrio™ • Recombivax HB®	Hepatitis B — HepB
• Twinrix®	Hepatitis A & B — HepA-HEPB
• M-M-R II® • Priorix®	Measles, mumps, rubella vaccine — MMR
• ProQuad®	Measles, mumps, rubella and varicella vaccine — MMRV
• Menveo®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-CRM
• Menactra®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-D
• MenQuadfi®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-TT
• Bexsero®	Meningococcal serogroup B vaccine — MenB-4C
• Trumenba®	Meningococcal serogroup B vaccine — MenB-FHbp
• Vaxneuvance™	Pneumococcal 15-valent conjugate vaccine — PCV15
• Prevnar 20™	Pneumococcal 20-valent conjugate vaccine — PCV20

Vaccines that are covered and have no age requirement	
Vaccine	**Common name and abbreviation**
• Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine — PPSV23
• IPOL®	Poliovirus — IPV
• Arexvy™ • Abrysvo™	Respiratory syncytial virus — RSV
• Rotarix®	Rotavirus vaccine — RV1
• RotaTeq®	Rotavirus vaccine — RV5
• Tdvax® • Tenivac®	Tetanus and diphtheria vaccine — Td
• Adacel® • Boostrix®	Tetanus, diphtheria and acellular pertussis vaccine — Tdap
• Varivax®	Varicella vaccine — VAR or chickenpox
• Shingrix®	Zoster vaccine — RZV or shingles

Vaccines that have an age requirement **Note:** If a member doesn't meet the age requirement for a vaccine, Blue Cross and BCN won't cover it under the prescription drug plan, and the claim will reject.		
Vaccine	**Common name and abbreviation**	**Age requirement**
• Pfizer	COVID-19 vaccine, 2023-2024	6 months through 4 years old, 5 through 11 years
• Comirnaty • Pfizer • Spikevax • Moderna	COVID-19 vaccine, 2023-2024	12 years and older
• 12 years and older	Human papillomavirus vaccine — HPV	9 to 45 years old
• Influenza virus	Influenza vaccine — Flu	Under 9 years: 2 vaccines per 180 days 9 years and older: 1 vaccine per 180 days
• Prevnar 13®	Pneumococcal 13 — valent conjugate vaccine	65 years and older

Pharmacy News

Starting Jan. 1, we're changing how we cover some drugs on our Clinical, Custom, Custom Select and Preferred Drug Lists

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 continually review prescription drugs to help ensure we provide the best value for our members, control costs and make sure our members are using the right drug for the right situation.

Starting Jan. 1, 2024, we'll change how we cover some medications on the Clinical, Custom, Custom Select and Preferred Drug Lists. The following lists detail these changes.

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

Clinical, Custom and Custom Select Drug List changes

Drugs that won't be covered on the Clinical, Custom and Custom Select Drug Lists

We'll no longer cover the following drugs. Unless noted, both the brand name and available generic equivalents won't be covered. If a member fills a prescription for one of these drugs on or after Jan. 1, 2024, the member will be responsible for the full cost.

The drugs that won't be covered are listed 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 lists	Common use or drug class	Preferred alternatives
Generic doxycycline monohydrate 75mg capsule	Custom Select	Tetracycline antibiotic	Generic doxycycline hyclate capsule; 100mg tablet; generic doxycycline monohydrate 50mg, 100mg capsule; 50mg, 75mg, 100mg tablet
APO-varenicline	Clinical, Custom, Custom Select	Smoking cessation	Generic varenicline tartrate (Chantix®)
Copaxone® 20mg/mL (brand glatiramer)	Custom Select	Multiple sclerosis	Generic glatiramer 20mg/mL, 40mg/mL (Glatopa®)

Drugs that will have a higher copayment on the Clinical, Custom and Custom Select Drug Lists

The brand-name drugs that will have a higher copayment are listed 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 lists	Common use or drug class	Preferred alternatives
Generic doxycycline monohydrate 75mg capsule	Custom (HMO only)	Tetracycline antibiotic	Generic doxycycline hyclate capsule; 100mg tablet; generic doxycycline monohydrate 50mg, 100mg capsule; 50mg, 75mg, 100mg tablet
Generic doxycycline monohydrate 150mg tablet	Custom (HMO only) Custom Select (HMO only)		
Copaxone® 20mg/mL (brand glatiramer)	Clinical, Custom	Multiple sclerosis	Generic glatiramer 20mg/mL, 40mg/mL (Glatopa®)

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

Brand name drugs no longer covered with a generic copay on the HMO Custom Drug List

On some of our drug lists, select brand-name drugs are covered at a generic copay and the generic equivalent drug isn't covered. These brand-name drugs will no longer be covered at the generic copay. Members can fill prescriptions with the generic equivalent.

Brand-name drug	Common use or drug class	Preferred alternatives
Adderall® XR	Custom (HMO only)	Dextroamphetamine / amphetamine ER capsule

Preferred Drug List changes

Drugs that won't be covered on the Preferred Drug List

We'll no longer cover the following drugs. Unless noted, both the brand-name and available generic equivalents won't be covered. If a member fills a prescription for one of these drugs on or after Jan. 1, 2024, the member will be responsible for the full cost.

The drugs that won't be covered are listed 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
Adhansia® XR	Attention-deficit/hyperactivity disorder (ADHD)	Generic methylphenidate (such as Ritalin® LA, Concerta®), generic dexmethylphenidate (such as Focalin® XR), generic amphetamine / dextroamphetamine (such as Adderall® XR), lisdexamphetamine (Vyvanse®)
Aklief®, Arazlo®	Acne vulgaris	Generic adapalene 0.1% cream, gel (Differin®); generic adapalene-benzoyl peroxide gel 0.1-2.5% (Epiduo®), generic tazarotene 0.1% cream, gel (Tazorac®)
Aplenzin®, Forfivo XL®, bupropion ER 450mg (authorized brand alternative for Forfivo XL®)	Depression	Generic bupropion ER (Wellbutrin® SR/XL)
APO-varenicline	Smoking cessation	Generic varenicline tartrate (Chantix®)
Copaxone® 20mg/mL (brand glatiramer)	Multiple sclerosis	Generic glatiramer 20mg/mL, 40mg/mL (Glatopa®)
Generic dapsone 7.5% gel (Aczone®)	Acne vulgaris	Generic dapsone 5% gel (Aczone®)

Pharmacy News

Drugs that won't be covered	Common use or drug class	Preferred alternatives
Evekeo ODT®	Attention-deficit/hyperactivity disorder (ADHD)	Generic dextroamphetamine solution (ProCentra®), generic methylphenidate solution, chewable tablet (Methylin®)
FloLipid®	Hypercholesterolemia	Generic statin (such as rosuvastatin (Crestor®), fluvastatin (Lescol XL®), atorvastatin (Lipitor®), pravastatin (Pravachol®), simvastatin (Zocor®))
Impoyz®	High-potency topical steroid	Generic high-potency topical steroid (such as betamethasone 0.5% cream, lotion; desoximetasone 0.25% cream, diflorasone 0.5% cream, flucinonide 0.5% cream, lotion; halcinonide 0.1% cream)
Lexette®, Ultravate® 0.05% lotion	Ultra-high-potency topical steroid	Generic ultra-high-potency topical steroid (such as clobetasol 0.05% cream, foam, spray; flucinonide 0.1% cream, halobetasol 0.05% cream, lotion)
Kristalose® packet	Constipation	Generic lactulose oral solution
Generic meclizine 50mg tablet	Vertigo, motion sickness	Generic meclizine 12.5mg, 25mg tablet
Ortikos®	Crohn's disease	Generic budesonide 3mg capsule
Osmolex ER®	Parkinson's disease	Generic amantadine tablet, solution
Oxaydo®	Pain	Generic oxycodone tablet
Phenergan Fortis® 25mg/5mL syrup	Nausea and vomiting	Generic promethazine 6.25mg/5mL syrup
Kristalose® packet	Constipation	Generic lactulose oral solution
Roszet®	Hypercholesterolemia	Generic ezetimibe (Zetia®) plus generic rosuvastatin (Crestor®)
Sernivo®	Moderate-potency topical steroid	Generic moderate-potency topical steroid (such as betamethasone 0.12% foam, desoximetasone 0.05% cream, fluticasone 0.05% cream, lotion; mometasone 0.1% cream, lotion; triamcinolone 0.2% spray)
Sprix®	Pain	Generic ketorolac tablet, injection
Generic tavaborole (Kerydin®)	Onychomycosis (nail fungus)	Ciclodan topical solution
Teriparatide 620 mcg/ 2.48mL injection	Osteoporosis	Forteo®, Tymlos®

Drugs that won't be covered	Common use or drug class	Preferred alternatives
Tosymra®	Migraine	Generic triptan (such as sumatriptan nasal spray (Imitrex®), zolmitriptan 5mg nasal spray (Zomig®), orally-disintegrating tablet (Zomig ZMT®); rizatriptan orally-disintegrating tablet (Maxalt-ODT®))
Wynzora®	Plaque psoriasis	Generic calcipotriene/betamethasone ointment (Taclonex®), generic tazarotene 0.1% cream (Tazorac®), Enstilar®
Xerese®	Herpes labialis (cold sores)	Generic acyclovir 5% ointment
Zilxi®	Rosacea	Generic azelaic 15% gel (Finacea®), generic metronidazole 0.75% cream, lotion (MetroCream®, MetroLotion®), Finacea® foam

Drugs that will have a higher copayment on the Preferred Drug List

The brand-name drugs that will have a higher copayment are listed 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	Common use or drug class	Preferred alternatives
Nulev®	Gastrointestinal conditions	Generic hyoscyamine sulfate 0.125mg, 0.375mg tablet (such as Levsin®, Levbid®)
Sucraid®	Congenital sucrase-isomaltase deficiency	Discuss treatment options with your provider.
Xywav®	Narcolepsy, Idiopathic hypersomnia	Discuss treatment options with your provider.
Zomig® 2.5mg nasal spray	Migraine	Generic triptan (such as sumatriptan nasal spray (Imitrex®), zolmitriptan 5mg nasal spray (Zomig®), orally-disintegrating tablet (Zomig ZMT®); rizatriptan orally-disintegrating tablet (Maxalt-ODT®))

Pharmacy News

Brand name drugs with a generic copay that won't be covered on the Preferred Drug List

On some of our drug lists, select brand-name drugs are covered at a generic copay and the generic equivalent drug is not covered. These brand-name drugs will no longer be covered at the generic copay. Members can fill prescriptions with the generic equivalent, and the brand-name drug will no longer be covered.

Drugs that won't be covered	Covered generic equivalent
Adderall® XR	Dextroamphetamine / amphetamine ER capsule
Advair® Diskus®	Fluticasone propionate / salmeterol Diskus, Wixela® Inhub®
Firazyr®	Icatibant acetate injection
Lialda®	Mesalamine 1.2g tablet
Targretin® capsule	Bexarotene capsule
Targretin® gel	Bexarotene gel

Pharmacy News

We'll require prior authorization for some diabetes drugs, starting Jan. 1

We continually review prescription drugs to provide the best value for our members, control costs and make sure members are using the right drug for the right situation.

Starting Jan. 1, 2024, certain diabetes medications will require prior authorization as described below for members with the following coverage:

- Medicare Plus Blue℠
- BCN Advantage℠

Also starting Jan. 1, 2024, the presence of prior pharmacy claims for insulin alone will no longer qualify certain diabetes medications for coverage for the following members:

- Blue Cross commercial
- BCN commercial

The drugs affected by these changes include:

Brand-name medication	FDA-approved indication	Coverage criteria
• Bydureon® • Byetta® • Mounjaro® • Ozempic® • Rybelsus® • Trulicity® • Victoza®	Type 2 diabetes	Prior authorization is not required if either of the following criteria are met: 1. Member has a prior claim for a Type 2 diabetes drug in his or her pharmacy claims history 2. Member has diagnosis of Type 2 diabetes in his or her medical claims history Providers must submit a prior authorization request for coverage if neither criterion described above are met.

For patients with Medicare Advantage coverage

Health care providers prescribing any of the medications listed above will need to request prior authorization for Medicare Plus Blue℠ and BCN Advantage℠ members who don't have a supporting prescription or medical record with a diabetes diagnosis.

The prior authorization will only be approved if the drug is used for an approved indication. Original Medicare prohibits Part D plans from covering drugs used for weight loss.

For a complete list of drugs and associated requirements, go to **2023 Drug Lists**.

For patients with Blue Cross or BCN commercial coverage

Coverage **without** prior authorization will require diagnosis of Type 2 diabetes verified through one of these methods:

1. Trial of one generic or preferred medication for the treatment of Type 2 diabetes within the prior 12-month period, **except** for metformin, GLP-1 receptor agonist or **insulin***
2. Diagnosis code for Type 2 diabetes identified in medical claim history within the prior 24-month period

If neither of the coverage criteria outlined above are fulfilled, you must request prior authorization to confirm that your patient has a diagnosis of Type 2 diabetes for coverage.

*Starting Jan. 1, 2024, previous trial of only insulin will no longer qualify a member for coverage without prior authorization if they don't have a medical diagnosis of Type 2 diabetes.

Helpful information

We'll let your affected patients know about this change and encourage them to speak with you about any concerns.

For information on how to submit the request electronically, view the flyer, **Save time and submit your prior authorization requests electronically for pharmacy benefit drugs**.

For more information on how to submit an authorization electronically:

1. Go to **ereferrals.bcbsm.com**.
2. Select *Blue Cross* for PPO members or *BCN* for HMO members.
3. Click *Pharmacy Benefit Drugs* on the left.

A complete list of included drugs and coverage requirements for all drug lists is available at **bcbsm.com/druglists**.

Pharmacy News

Review requirements for prior authorization of Omisirge

Omisirge® is a new-to-market cellular therapy that was recently approved by Blue Cross Blue Shield of Michigan's and Blue Care Network's Pharmacy and Therapeutics committee.

On May 23, 2023, we published a **provider alert** stating that Omisirge will require prior authorization for most commercial members for dates of service on or after June 8, 2023. The member **must have an approval for a stem cell transplant on file** through Blue Cross' and BCN's Human Organ Transplant Program before a prior authorization request for Omisirge can be approved.

You can view the complete requirements in our Omisirge medical policy. To access the medical policy:

1. Go to **bcbsm.com/providers**.
2. Click on *Resources*.
3. Click on *Search Medical Policies*.
4. In the ***Medical Policy Router Search*** page, type "Omisirge" in the *Policy/Topic Keyword* field and press Enter.
5. Click on the link to open the Omisirge medical policy.

Zynyz to require prior authorization for most members starting Dec. 10

For dates of service on or after Dec. 10, 2023, the following drug will require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®):

- Zynyz™ (retifanlimab-dlwr), HCPCS code J9345

The drug is covered under medical benefits, not pharmacy benefits.

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

- Blue Cross Blue Shield of Michigan commercial —
  - All fully insured members (group and individual)
  - Members who have coverage through **self-funded groups that have opted in to the Carelon medical oncology program**. (Although UAW Retiree Medical Benefits Trust non-Medicare plans have opted into this program, these requirements may not apply; refer to their medical oncology drug list, which is linked below.)

  Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit authorization requests

Submit authorization requests to Carelon using one of the following methods:

- Through the Carelon ProviderPortal, which you can access by doing one of the following:
  - Logging in to our provider portal (**availity.com**), clicking *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space where you'll click the *Carelon ProviderPortal* tile.

    Note: If you need to request access to our provider portal, see the **Register for web tools** webpage on **bcbsm.com**.
  - Logging in directly to the Carelon ProviderPortal at **providerportal.com**
- By calling the Carelon Contact Center at 1-844-377-1278

More about the prior authorization requirements

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 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 Benefits 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 pertinent drug lists to reflect the information in this message prior to the effective date.

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

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

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

Lumoxiti will no longer require prior authorization starting Sept. 30

For dates of service on or after Sept. 30, 2023, the following drug will no longer require prior authorization through Carelon Medical Benefits Management (formerly known as AIM Specialty Health®):

- Lumoxiti™ (moxetumomab pasudotox-tdfk), HCPCS code J9313

This drug is covered under medical benefits, not pharmacy benefits.

This change applies to:

- Blue Cross and Blue Shield of Michigan commercial
  - All fully insured members (group and individual)
  - Members who have coverage through **self-funded groups that have opted in to the Carelon medical oncology program**. This includes members who have UAW Retiree Medical Benefits Trust non-Medicare plans.

  Note: This change doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

More about the prior authorization requirements

For 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 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 Benefits 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 pertinent drug lists to reflect the information in this message prior to the effective date.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

Requirements and codes changed for some 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 comprehensive lists of requirements for our members.

In July, August and September of 2023, we added requirements for some medical benefit drugs. These requirements went into effect on various dates.

In addition, some drugs were assigned new HCPCS codes.

Keep reading for the details you need to know.

Changes in requirements

For Blue Cross commercial and BCN commercial members: We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name
J3590*	Elevidys	Delandistrogene moxeparvovec-rokl
J3590*	Eylea® HD	Aflibercept
J3590*	Izervay™	Avacincaptad pegol
J3590*	Lantidra™	Donislecel-jujn
J3590*	Roctavian™	Valoctocogene roxaparvovec-rvox
J3590*	Rystiggo®	Rozanolixizumab-noli
J3590*	Tyruko®	Natalizumab-sztn
J3590*	Veopoz™	Pozelimab-bbfg
J3590*	Vyvgart® Hytrulo	Efgartigimod alfa and hyaluronidase-qvfc

For Medicare Plus Blue℠ and BCN Advantage℠ members: We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name	For dates of service on or after
J3590*	Elevidys	Delandistrogene moxeparvovec-rokl	7/10/2023
J3590*	Roctavian™	Valoctocogene roxaparvovec-rvox	7/10/2023
J3590*	Rystiggo®	Rozanolixizumab-noli	7/10/2023
J3490*	Vyvgart® Hytrulo	Efgartigimod alfa and hyaluronidase-qvfc	7/1/2023
J3590*	Qalsody™	Tofersen	8/1/2023
J3590*	Elfabrio®	Pegunigalsidase alfa-iwxj	8/14/2023
J3590*	Vyjuvek™	Beremagene geperpavec-svdt	8/14/2023
J3590*	Veopoz™	Pozelimab-bbfg	9/1/2023

Code changes

The table below shows HCPCS code changes that were effective July 1, 2023, (unless otherwise noted), for the medical benefit drugs we manage.

New HCPCS code	Brand name	Generic name
J1440	Rebyota™	Fecal microbiota, live-jslm
J1576	Panzyga®	Immune globulin intravenous (human) – ifas 10%
J9381	Tzield®	Teplizumab-mzwv
J9029	Adstiladrin®	Nadofaragene firadenovec-vncg
J0174 (effective 7/6/2023)	Leqembi®	Lecanemab-irmb

Drug lists

For additional details, see the following drug lists:

- For commercial members: **Blue Cross and BCN utilization management medical drug list**
- For Medicare Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

These lists are also available on the following pages of the **ereferrals.bcbsm.com** website:

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

Additional information about these requirements

We communicated these changes previously through provider alerts. Those alerts contain additional details.

You can view the provider alerts on **ereferrals.bcbsm.com** and on our Provider Resources site, which is accessible through our provider portal (**availity.com**).

Additional information for Blue Cross commercial groups

For Blue Cross commercial groups, authorization requirements apply only to groups that 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

Reminder

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

*May be assigned a unique code in the future.

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

Starting Jan. 1, 2024, all DME codes will be removed from the CareCentrix HIT and AIS program

This is an update to an article we published in the September-October 2023 issue of *BCN Provider News* and the September 2023 issue of *The Record*. In those previous articles, the table with the HCPCS codes contained errors. This article shows the correct HCPCS codes that will be removed from the CareCentrix HIT and AIS program starting Jan. 1, 2024.

For dates of service on or after Jan. 1, 2024, the durable medical equipment codes listed in the table below will be removed from the CareCentrix network management program for home infusion therapy and ambulatory infusion suite providers.

HCPCS codes					
B4034	B4035	B4036	B4081	B4082	B4083
B4087	B4102	B4103	B4104	B4105	B4149
B4150	B4152	B4153	B4154	B4155	B4157
B4158	B4159	B4160	B4161	B4162	B4185
B4187	B9002	B9998			

This change applies to:

- Blue Cross Blue Shield of Michigan and Blue Care Network commercial members
- Independent home infusion therapy and ambulatory infusion suite providers

Note: Ambulatory infusion suite providers are a subset of ambulatory infusion centers.

These codes are still part of the DME benefit. Providers who participate in the Blue Cross or BCN DME network can bill them in line with existing Blue Cross or BCN billing guidelines.

Prior to Jan. 1, 2024, we'll update the **Home infusion therapy and ambulatory infusion suite provider network management: Frequently asked questions** document to reflect this change.

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.

Pharmacy News

New location for pharmacy services information for providers on our public website

We have relocated our pharmacy services information for providers on our public website. This location contains information on medical and pharmacy benefit drug lists for both Blue Cross and Blue Care Network, Medicare and pharmacy forms and documents, prior authorization request information and other resources. Here's how to find it:

1. Go to **bcbsm.com/providers**.
2. Click the *Resources* tab.
3. Scroll down to the section labeled *Pharmacy information* and click *Access pharmacy resources* to open the **Pharmacy Resources for Providers** webpage.

Billing Bulletin

BCN transitions reimbursement method for some urgent care providers

Effective Jan. 1, 2024, Blue Care Network will be transitioning some providers currently receiving global or per diem reimbursement to the Urgent Care Fee Schedule. This change supports the BCN strategy to implement a consistent reimbursement method across urgent care providers and won't negatively affect reimbursement for the transitioned providers. This applies to covered services for BCN commercial and BCN Advantage℠ members.

We'll mail a letter to providers affected by this change. To obtain a copy of the fee schedule, contact **FeeSchedule@bcbsm.com**.

Here are some key guidelines for NICU billing

When billing room and board services for new admissions of pediatric patients outside the defined newborn age of 28 days or less, health care providers should use the appropriate corresponding pediatric room and board revenue codes.

According to ICD-10-CM classification guidelines, a newborn is defined as a baby who is in the first 28 days of life. Critical care services for the newborn take place in a nursery or neonatal intensive care unit, also called NICU, and are represented by revenue codes 0170-0174. A medical condition that presents after the first 28 days of life is no longer considered a newborn condition.

Exclusions to this billing guideline are when the patient is transferred from the birth hospital to another hospital for non-routine care, with services beginning during the newborn period.

Newborn and pediatric revenue codes and descriptions:

0170	Room and Board Nursery	Used for routine newborn care
0171	Newborn Level 1	Used for non-routine newborn care
0172	Newborn Level II	Used for non-routine newborn care
0173	Newborn Level III	Used for non-routine newborn care
0174	Newborn Level IV	Used for non-routine newborn care
0113	Pediatric Room and Board	Private
0123	Pediatric Two Beds	Semi-private
0203	Pediatric Intensive Care	Used for intensive pediatric care

None of the information included 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.

Clinical editing billing tips

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

This issue's tips:

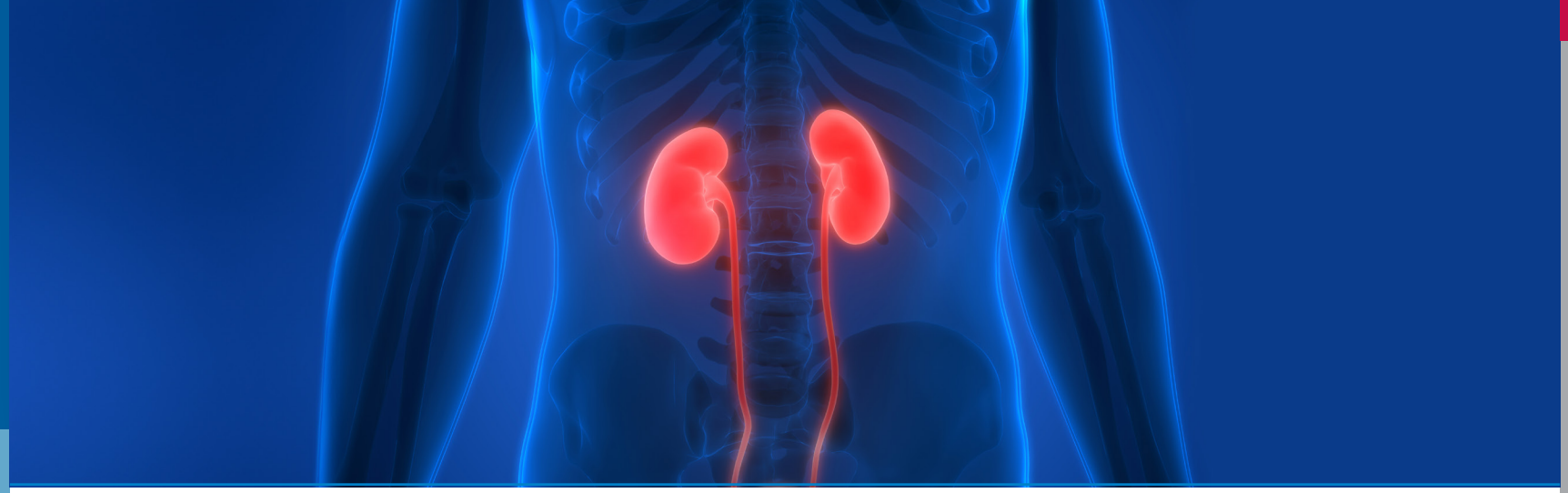
- Superficial radiation therapy-related edits
- Clear Claim Connection tool not to be used for Blue Care Network and BCN Advantage
- Time-based procedures and HCPCS codes

Clinical Editing Billing Tips

Here are some other articles in this issue that may be of interest

- *Newly enrolled PAs and NPs are required to identify their work settings to help avoid payment issues,* **Page 4**
- *Lunch and learn webinars for physicians and coders focus on risk adjustment, coding,* **Page 5**
- *Update: Starting Jan. 1, 2024, all DME codes will be removed from the CareCentrix HIT and AIS program,* **Page 34**

Referral Roundup



Kidney-only transplants to require prior authorization, starting Jan. 1

For dates of service on or after Jan. 1, 2024, hospital transplant financial coordinators must submit prior authorization requests for kidney-only transplants through the e-referral system for:

- Blue Cross Blue Shield of Michigan fully insured group and individual commercial members
- Blue Care Network fully insured group and individual commercial members
- All BCN Advantage℠ members

As with other transplants that already require prior authorization — including simultaneous pancreas-kidney, or SPK — it's a two-step process in the e-referral system:

1. Submit an **outpatient** prior authorization request that includes:
   - Procedure codes *50360 and *50365
   - The facility
     - For commercial members, enter a Blue Distinction® Center for Transplants.
     - For BCN Advantage members, enter a facility that's accredited by the Centers for Medicare & Medicaid Services for kidney transplants.
   - The completed questionnaire — the questionnaire automatically opens in the e-referral system for you to fill out.
   - Clinical information — include the history and physical, the letter of intent and clinical documentation to support the need for the transplant.

The request will pend for clinical review. In addition, the request will require medical director review if the facility **isn't** a Blue Distinction Center for Transplants (for commercial members), the facility isn't accredited by CMS for kidney transplants (for BCN Advantage members) or the member doesn't meet medical policy criteria.

If the authorization is approved, it will be valid for one year.

2. When a kidney becomes available, submit a prior authorization request for the inpatient stay. **Include the outpatient authorization number for the transplant procedure codes in the *Case Communication* field.** This will enable us to issue an approval quickly as it makes the connection between the inpatient request and the already-approved outpatient authorization.

You'll be able to start submitting requests through the e-referral system for kidney-only transplants on Jan. 1, 2024.

We'll update the ***e-referral User Guide*** for kidney-only transplants before Jan. 1. The pertinent information will be in "Section IV: Referrals and Authorizations," in the subsection titled "5. Submit an Outpatient Authorization." (The *e-referral User Guide* also includes information about submitting a re-authorization request, if the authorization obtained through Step 1, mentioned above, expires before a kidney becomes available.)

Notes:

- For more information about ***Blue Distinction Centers***, see the Blue Distinction Centers webpage on our **ereferrals.bcbsm.com** website.
- If the e-referral system isn't available or isn't performing as expected, see the document titled ***e-referral system maintenance times and what to do***.
- This prior authorization requirement for kidney-only transplants is already in place for the Blue Cross and Blue Shield Federal Employee Program® members.

Prior authorization no longer required for some procedures, starting Jan. 1

For dates of service on or after Jan. 1, 2024, the following procedures will no longer require prior authorization.

Note: For dates of service before Jan. 1, these procedures require prior authorization by Medicare Plus Blue℠ and BCN Utilization Management.

Procedure	Applies to	Affected procedure codes
Biofeedback, non-behavioral health	• BCN commercial • BCN Advantage℠	*90901, *90912
Deep brain stimulation	• Medicare Plus Blue • BCN commercial • BCN Advantage	*61863, *61864, *61867, *61868, *61880, *61885, *61886, *61888
Noncoronary vascular stents	• Medicare Plus Blue • BCN commercial • BCN Advantage	*37236, *37238
Total artificial heart	• BCN commercial • BCN Advantage	*0051T, *0052T, *0053T, *33927, *33928, *33975, *33976, *33977, *33978, *33979, *33980, *33981, *33982, *33983, *33990, *33991, *33992, *33993, *33995, *33997

Prior to Jan. 1, we'll update lists of procedure codes that require prior authorization.

Referral Roundup

Management of outpatient diabetes supplies for additional members, starting Jan. 1

Starting Jan. 1, 2024, Northwood Inc., an independent company, will manage outpatient diabetes supplies that are covered under the medical benefit for Medicare Plus Blue℠, BCN commercial and BCN Advantage℠.

For these members, Northwood will:

- Maintain the statewide provider network for durable medical equipment and prosthetic and orthotic supplies and services
- Receive and make determinations on prior authorization requests
- Process and pay claims for covered services

Outpatient diabetes supplies include items such as continuous glucose monitors, insulin pumps and supplies, and testing supplies.

Contact Northwood starting Jan. 1

Starting Jan. 1, for diabetes supplies for Medicare Plus Blue, BCN commercial and BCN Advantage members, providers can call Northwood at 1-800-393-6432 to locate the nearest supplier contracted with Northwood. The contracted supplier:

- Submits the prior authorization requests to Northwood for review
- Submits the claims directly to Northwood

Providers who currently submit orders directly to J&B Medical may continue to do so. J&B Medical is an independent company that participates in the Northwood network.

Update: New and updated TurningPoint medical policies for musculoskeletal and pain management procedures

In the September *Record* and the September-October *BCN Provider News*, we reported that Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Healthcare Solutions LLC added and updated TurningPoint medical policies for musculoskeletal and pain management procedures.

The newsletter articles linked to a provider alert for details. We're letting you know that we updated the provider alert to:

- Add the *Intraosseous Basivertebral Nerve Ablation (Intracept)* medical policy to the list of new TurningPoint medical policies.
- State that the new and updated medical policies apply to prior authorization requests submitted on or after Oct. 1, 2023 — not to dates of service on or after Oct. 1, as previously reported.

View the **updated provider alert** for full details.

Look for status note in e-referral system when we pend prior authorization requests for some services

In the Blue Cross Blue Shield of Michigan and Blue Care Network e-referral system, we're adding a status note to let health care providers know when we've pended prior authorization requests for initial admissions to and extensions of stays in:

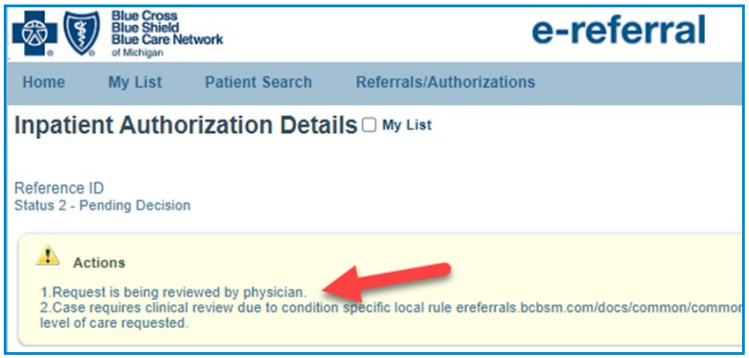
- Acute (non-behavioral health) inpatient hospitals
- Skilled nursing facilities, acute inpatient rehabilitation facilities and long-term acute care hospitals — for commercial members only

Note: As a reminder, naviHealth manages these requests for Medicare Plus Blue℠ and BCN Advantage℠ members.

We recently implemented this function to make it easier for providers to see the status of their requests. Here's how it works:

When a Blue Cross or BCN Utilization Management staff member pends a prior authorization request for review by a medical director, a status note appears in the upper-left portion of the *Inpatient Authorization Details* screen.

The status note says, "Request is being reviewed by physician," as shown below.



The status note is displayed for Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage requests that are managed by Blue Cross and BCN Utilization Management.

When we make a determination on the request — whether an approval or a denial — you'll no longer see the status note.

Previously, when we pended a request, we added a statement to that effect in the Case Communication field.

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

Referral Roundup

New and updated questionnaires in e-referral system

In July, August and September, we added and updated questionnaires in the e-referral system. We also updated the corresponding preview questionnaires and authorization criteria 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 questionnaire

We added the following questionnaires.

Questionnaire	Opens for	Details	Effective date
Balloon ostial dilation	• Medicare Plus Blue • BCN commercial • BCN Advantage	Began opening for procedure codes *31295, *31296, *31297 and *31298 **Note:** For dates of service on or before Aug. 27, 2023, the *Sinusotomy* questionnaire opened for these procedure codes.	Sept. 24, 2023
Deep brain stimulation	• BCN commercial members with Healthy Blue Choices℠ POS plans	Began opening for procedure codes *01966, *59100, *59840, *59841, *59850, *59851, *59852, *59855, *59856, *59857, *59866, S0190, S0191 and S0199	Sept. 24, 2023

Updated questionnaires

We updated the following questionnaires on the dates specified below:

Questionnaire	Opens for	Details	Effective date
Blepharoplasty	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated a question	July 30, 2023
Chemical peels	• BCN commercial • BCN Advantage	Updated a question	July 30, 2023
Deep brain stimulation	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated two questions	Aug. 27, 2023
Ethmoidectomy	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated several questions	July 30, 2023
Endovascular intervention, peripheral artery	• Medicare Plus Blue • BCN Advantage	No longer opens for procedure codes *0238T, *34101, *34111, *34151, *34201, *34203, *37184 and *37222 Effective Sept. 1, 2023, this questionnaire no longer opens for BCN commercial members because these procedures are managed by Carelon Medical Benefits Management.	Aug. 27, 2023
Orthoptic and pleoptic visual training	• BCN commercial • BCN Advantage	Began opening for procedure code *92066. (Continues to open for procedure code *92065.)	Sept. 24, 2023
Pregnancy termination 3 — elective	• BCN commercial	No longer opens for procedure codes S2260, S2265, S2266 and S2267 Updated questions	Sept. 24, 2023
Responsive neurostimulator/deep brain stimulation trigger	• BCN commercial • BCN Advantage	Updated the question	Aug. 27, 2023

Questionnaire	Opens for	Details	Effective date
Responsive neurostimulation for the treatment of refractory focal epilepsy	• BCN commercial • BCN Advantage	Updated the title of the questionnaire to align with title of the updated medical policy.	Aug. 27, 2023
Septoplasty	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated two questions	Aug. 27, 2023
Sinusotomy	• Medicare Plus Blue • BCN commercial • BCN Advantage	No longer opens for procedure codes *31295, *31296, *31297 and *31298 Removed questions related to balloon ostial dilation Updated several questions	Aug. 27, 2023
Thyroidectomy, total	• Medicare Plus Blue • BCN commercial • BCN Advantage	Updated five questions	Aug. 27, 2023

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time. To access them, go to **ereferrals.bcbsm.com** and:

- **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**. Scroll down and look under the "Authorization criteria and preview questionnaires – Medicare Plus Blue" heading.

Authorization criteria and medical policies

The Authorization Requirements & Criteria pages explain how to access the pertinent authorization criteria and medical policies.

Here are some other articles in this issue that may be of interest

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