JANAUARY–FEBRUARY 2024

BCN Provider News

Blue Cross and BCN receive 4-Star Ratings from CMS

The Centers for Medicare & Medicaid Services recently announced its 2024 Medicare Star Ratings. Both our BCN Advantage℠ HMO plan and our Medicare Plus Blue℠ PPO plan captured 4-Star Ratings, making our plans once again among the highest rated Medicare Advantage plans in the country.

Star Ratings are CMS' measure of how well health plans serve MA members. 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.

"Star Ratings are vital to our mission to serve our Medicare Advantage members," said Daniel J. Loepp, Blue Cross Blue Shield of Michigan president and CEO. "We value the provider community's partnership when it comes to delivering exceptional, high-quality care — a key factor that drove our strong ratings."

Why value-based care matters when it comes to Star Ratings

The measures that the Star Ratings system considers overlap with value-based care model outcomes. Health care providers who are in value-based care arrangements outperform their peers in key measures related to quality and cost, including better performance in rates of breast cancer and colorectal screenings, and diabetic control measures.

"When we look at these performance measures and how our Star Ratings are calculated, it's clear that value-based care is a winning path forward for everyone," said Dr. James Grant, senior vice president and chief medical officer for Blue Cross. "We couldn't have achieved these Star Ratings without our physician partners, and we look forward to the future as we continue to meaningfully engage everyone in value-based arrangements that will benefit our members."

The goal for the 2025 rating year is to maintain or exceed 4-Star Ratings for the PPO and HMO.

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BCN Provider News

A deeper dive into the ratings

Medicare considers five categories when assigning Star Ratings:

- Maintaining health for members, including benefits such as cancer screenings and vaccines
- Managing chronic conditions, such as diabetes and blood pressure
- Customer service, including 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
- Member experience with their plan, quality of care received and access to care

Blue Cross' 4-Star ratings for 2024 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.

**HEDIS®, which stands for Healthcare Effectiveness and 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.

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Office staff can join Provider Advisory Panel

Blue Cross Blue Shield of Michigan and Blue Care Network are adding members to our Provider Advisory Panel.

- Are you an office staff person, such as an office manager, biller, referral or authorization coordinator, who works for a professional practice or a hospital or facility?
- Would you like the opportunity to provide feedback on current Blue Cross or BCN programs, share your thoughts on new initiatives and help us work together more effectively?

If you said yes to the above two questions, then the Provider Advisory Panel may be for you.

Current panel members have provided input that guided strategy on several topics, including:

- Virtual ID card usage
- Improving your experience using the ereferrals.bcbsm.com website
- The new *Provider Alerts Weekly publication*

If you'd like to be considered for membership on the Provider Advisory Panel, complete the **Provider Advisory Panel Interest Form**. Space is limited. If we're unable to include you in the 2024 panel, we'll keep you on a list to fill a potential future opening.

For more information about the Provider Advisory Panel, email **ProviderAdvisoryPanel@gongos.com**.

We auto-assign a primary care provider on first day of coverage for certain BCN commercial members

We automatically assign a primary care provider on the first day of coverage for new Blue Care Network members who have:

- A Blue Cross® Metro Detroit HMO plan
- A Blue Cross® Local HMO plan

Specific provider networks are associated with these plans.

This is a change that started Oct. 1, 2023.

Keep reading to learn the details.

Starting Oct. 1, 2023

- For members who are new to BCN and who enroll in one of these plans, we assign the primary care provider based on the member's ZIP code.
- For existing BCN members who move to one of these plans, one of the following occurs:
  - If the member's current primary care provider is part of the network associated with the new plan, that provider will continue as their primary care provider under the new plan.
  - If the member's current primary care provider isn't part of the network associated with the new plan, we assign the primary care provider based on the member's ZIP code. The provider is part of the network that's associated with the member's plan.

Note: The Blue Cross Metro Detroit HMO and the Blue Cross Local HMO plans and provider networks are the only ones affected by this change. For all other BCN commercial plans, the member has 60 days after enrolling to select a primary care provider before one is automatically assigned.

Before Oct. 1, 2023

Members who enrolled in these plans before Oct. 1, 2023, and who hadn't selected a primary care provider were automatically assigned to one within 60 days of enrolling.

Additional information

We've made this change to help ensure claims for the Blue Cross Metro Detroit HMO and Blue Cross Local HMO plans and provider networks are paid appropriately.

BCN members can change their primary care provider assignment at any time. For members with a Blue Cross® Metro Detroit HMO or Blue Cross® Local HMO plan, the primary care provider they select must be part of the network associated with the plan.

Network Operations

Reminder: Point of service health plans don't require referrals

POS health plan referrals should not be submitted via e-referral

Blue Care Network POS health plans don't require referrals. Beginning in March 2024, the e-referral system won't accept referrals submitted for BCN POS health plans.

Blue Care Network point of service health care plans allow members to receive covered services with any health care provider, in or out of network, with **no referral required**. Beginning in March 2024, the e-referral system won't accept referrals submitted for BCN POS health plans.

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

- BCN point of service health plan plastic member ID cards feature the BCN logo as well as the health plan name, which includes "POS" (for example, Blue Elect Plus℠ POS, Healthy Blue Choices℠ POS).
- The back of BCN point of service health plan plastic member ID cards have a statement saying the POS plan doesn't require a referral.
- 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 referral required.

Although referrals aren't required, BCN POS health plan members will have lower out-of-pocket costs when they receive services from an in-network provider.

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

Network Operations

Where to view provider portal change and status updates

Are you curious about what's new with our provider portal, Availity® Essentials?

We're always working to improve your experience in our provider portal. Here are a couple of examples:

- We updated member search results to include the type of services that are covered (medical, behavioral health, pharmacy, hearing or vision) and to specify the time frame during which the member's coverage is in effect. In addition, search results now include group numbers and suffixes for members with Blue Cross Blue Shield of Michigan plans and group numbers for members with Blue Care Network plans.
- We updated the *Coordination of Benefits* section to display the payer as Blue Cross Blue Shield of Michigan, Medicare Plus Blue℠ or Blue Care Network, rather than displaying the more generic BCBS Michigan and Blue Care Network.

To stay up to date with the latest provider portal news, you can access the *Provider Portal Change and Status Updates* document, which includes information about important updates, known defects and workarounds. We update this document monthly or more often, as needed.

To view this document:

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 *News and Announcements* tab.
4. Click on the *Provider Portal Change and Status Updates (PDF)* link.

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.

Access our provider training site from the provider portal, new learning path available for medical coders and billing specialists

Action Item

You can now go to the provider training site directly through our provider portal. The dashboard is designed to enhance the training experience for health care providers and staff.

Provider Experience is happy to announce that you can now access our provider training site from our provider portal (**availity.com**).

To access the training site, follow these steps:

1. Log in to the provider portal.
2. Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
3. Click on the *Provider Training Site* tile under Applications.
4. Click *Submit* on the Select an Organization page.

Existing users that used the same email address as their provider portal profile email will be directed to the training site. If you used a different email address, please contact **ProviderTraining@bcbsm.com** to update your profile.

For new training site users:

1. Complete the one-time registration by entering your role and creating a password. This allows you to access the training site outside of the provider portal if needed.
2. One completed, you will only have to follow steps 1-4 moving forward.

If you need assistance navigating the provider training site, email **ProviderTraining@bcbsm.com**.

In addition, we continue to offer training resources for health care providers and staff. Our on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network. As part of our ongoing efforts, we recently added a new learning path.

New learning path on provider training website

Our newest learning path contains courses for medical coders, medical billing specialists and others that work with medical record documentation. This is our latest in the approach for helping providers determine the right courses to take. We'll keep updating the courses as new ones are created that cover coding and medical record documentation topics. This will ensure you have the latest information that is easy to find in one spot.

Professional providers and facilities should encourage medical coders, billers and records technicians to view the new path. Simply open the Course Catalog on the provider training website and click on *Learning paths*.

And don't forget to check the dashboard on our provider training site for announcements as we add more courses, including those that include continuing medical education (CME) credits.

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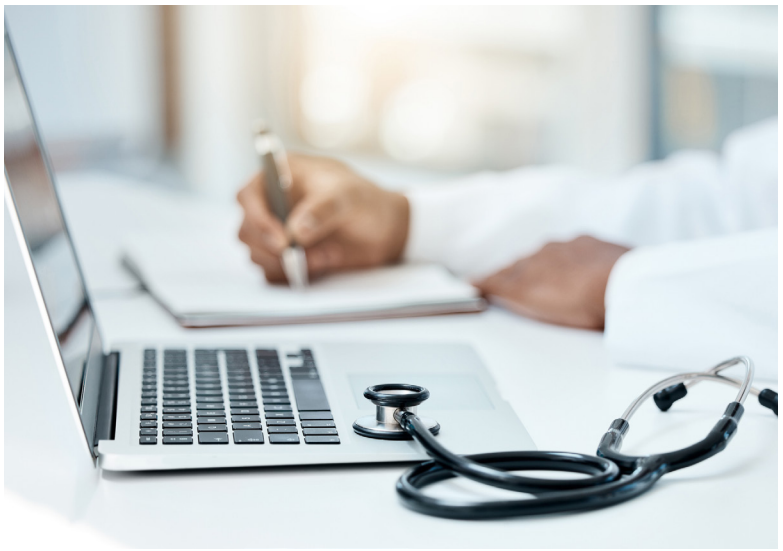

Update to current *Health e-Blue video tutorial* training course as well as new mini-lesson video

Action Item

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

Provider Experience continues to offer training resources for health care providers and staff. Our on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network.

We recently updated or added the following learning opportunities:

- *Health e-Blue video tutorial*

  This three-part video tutorial (that reviews how to use the *Quality summary report*, the *Treatment opportunities list*, and the *Healthy Blue Living qualification form*), now includes how to access the form.

- Finding *BCN Qualification form for Healthy Blue Living*

  This **new** micro-learning style video is a short tutorial on accessing the *BCN Qualification form* through our provider portal (**availity.com**). It provides quick insight on how to find the resource needed to complete the form for your patients.

  Note: For more information, refer to *Reminder: Qualification form required for Healthy Blue Living members*, **Page 14**.

The goal of our provider training site is to enhance the training experience for health care providers and staff. Check out the dashboard regularly for announcements as we add more courses, including those that include continuing medical education (CME) credits.

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, contact **ProviderTraining@bcbsm.com**.

Network Operations

Blue Care Network fee schedule update reminder

Blue Care Network commercial fee schedules are updated annually on July 1 with updates occurring monthly or quarterly, as needed. BCN Advantage℠ fee schedules are updated annually on January 1 with quarterly updates to align with changes from the Centers for Medicare & Medicaid Services.

BCN-contracted providers can obtain a copy of BCN fee schedules. Copies of some BCN fee schedules and instructions for obtaining others are available on the BCN Fee Schedules webpage within our provider portal. Here's how to find the BCN Fee Schedules webpage.

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 drop-down menu next to *Fee Schedules* in the menu bar and click on *BCN Fee Schedules*.

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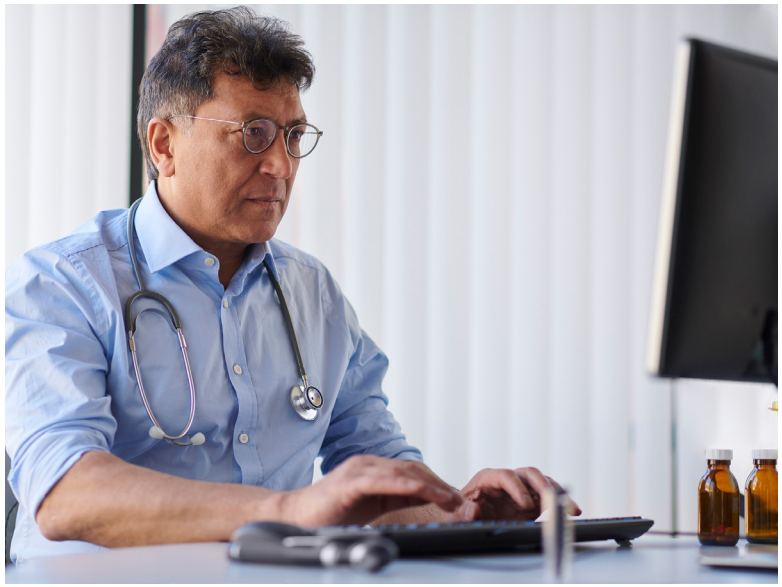

Here are some other articles in this issue that may be of interest

- *Virtual Care replacing Blue Cross Online Visits in January*, **Page 13**
- *Additional features now available for uploading medical records electronically*, **Page 41**
- *Reminder: Qualification form required for Healthy Blue Living members*, **Page 14**

BCN Advantage

Get ready for 2024 annual Medicare wellness visits

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

Welcome to Medicare visit

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

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

Billing code for Welcome to Medicare visit (Also called initial preventive physical examination)
*G0402

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 out-of-pocket cost applies.

BCN Advantage

Here are some other articles in this issue that may be of interest

- *Changes coming to infliximab step therapy requirements for Medicare Advantage members in January,* **Page 37**
- *Solid organ and bone marrow transplants won't require prior authorization for BCN Advantage members, starting Jan. 1,* **Page 48**
- *When reviewing inpatient admission requests, we'll continue to follow CMS guidelines and evidence-based criteria,* **Page 50**

Livongo is now Teladoc Health — information about diabetes, hypertension and weight management solutions

All solutions that were previously provided by Livongo® are now provided by Teladoc Health®.

Diabetes, hypertension and weight management solutions

Teladoc will continue to provide the following solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

Solution	Available to
Diabetes management	• All members who have coverage through commercial fully insured groups and members who have individual coverage • Some members who have coverage through commercial self-funded groups • All Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members
Diabetes prevention Hypertension management	• All members who have coverage through fully insured commercial groups and members who have individual coverage • Some members who have coverage through self-funded groups
Starting Jan. 1, 2024: Weight management	• All members who have coverage through fully insured commercial groups • Some members who have coverage through self-funded groups **Note:** This solution isn't available to members with individual coverage or to self-funded groups that don't purchase this solution. Other exclusions may apply.

Members can call the number on the back of their ID card to determine whether their coverage includes access to Teladoc solutions.

Continued on following page

What's changing

Members will access these solutions through the Teladoc app.

Although the current phone numbers and website addresses will continue to work for some time, the following new phone number and website address are also available:

- Phone number: 1-800-835-2362
- Website: **TeladocHealth.com/BCBSMI**

We're updating our communications to reflect these changes.

Additional information

For more information, see Teladoc Health's **Creating a new standard in the global delivery, access and experience of healthcare** webpage.

Teladoc Health® is an independent company that provides select care management services for Blue Cross Blue Shield of Michigan and Blue Care Network.

Virtual Care replacing Blue Cross Online Visits in January

What you need to know

Starting in January, Virtual Care by Teladoc Health® will replace Blue Cross Online Visits℠ for virtual urgent medical and mental health care.

Beginning in 2024, eligible Blue Cross Blue Shield of Michigan and Blue Care Network members will no longer use Blue Cross Online Visits℠ for virtual urgent and mental health care. On Jan. 1, 2024, all members with this benefit will use Virtual Care by Teladoc Health®.

Virtual Care will be available through the Teladoc Health app and website, and by phone. Members will still have access to virtual urgent care 24/7 and mental health care by appointment, including evenings and weekends.

We understand that many health care providers offer virtual visits directly through their office. We encourage providers who don't offer virtual visits to their patients to consider recommending Virtual Care to the Blue Cross and BCN members who express interest in it. Starting on Jan. 1, you can direct them to **bcbsm.com/virtualcare** or to call 1-800-835-2362, 24 hours a day, seven days a week.

View our **Virtual Care FAQ** for more information.

Urgent care

With Virtual Care, members have care when they need it. They can talk to a U.S. board-certified doctor when their primary care provider isn't available about minor illnesses such as:

- Sinus and respiratory infections
- Cold and flu
- Painful urination
- Eye irritation or redness
- Sore throat

Members can select *24/7 Care* in the Teladoc Health app or call the above phone number for assistance and to schedule an appointment.

Continued on following page

Mental health care

Members can select *Mental Health* in the Teladoc Health app to find and get care from licensed therapists and U.S. board-certified psychiatrists. They can also call 1-800-835-2362 to schedule an appointment. Visits are private and confidential and provide ongoing support for stressful situations or issues such as grief, anxiety and depression.

Members can start scheduling appointments on Jan. 1. Visits are available from 7 a.m. to 9 p.m. Eastern time, seven days a week. Psychotherapy with a psychologist or clinical social worker is available for members ages 13 and older, while members ages 18 and older can receive psychiatric services. Doctors don't prescribe controlled substances.

We encourage mental health care providers to speak with their patients who have Blue Cross and BCN health coverage about this transition and assist them with mental health strategies and resources. Share with them the **Blue Cross Behavioral Health** website and let them know they can call the behavioral health phone number on the back of their member ID cards for more information or if they have a behavioral health need.

Members can also log in to their Blue Cross member account at **bcbsm.com** or through the mobile app to use *Find Care* and identify a mental health care provider they may want to see. Members can use *Find Care* to confirm if a Blue Cross provider offers virtual visits.

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

Reminder: Qualification form required for Healthy *Blue* Living members

As a reminder, providers must complete and electronically submit the *Blue Care Network Qualification Form* on behalf of a Healthy *Blue* Living℠ HMO member in order for the member to receive enhanced benefits.

Each member is required to visit his or her primary care provider within 90 days of enrollment or renewal; however, there is **no limit** on the number of times a member can schedule a physical exam. BCN encourages each member to see their PCP well before the deadline and will accept the qualification form from an office visit occurring up to 180 days prior to the member's renewal date.

If a member should qualify for enhanced benefits but the primary care provider doesn't submit the qualification form, the member will have standard benefits for the rest of the year resulting in higher copays, coinsurance and deductibles.

Note: For more information, refer to *Update to current Health* e-Blue *video tutorial training course as well as new mini-lesson video*, **Page 8**.

Continued on following page

Patient Care/ Quality

Completing the qualification form

To complete the qualification form, you'll need access to our provider portal and Health e-Blue℠. To find the qualification form:

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 *BCN Qualification Form (for Healthy Blue Living)* on the Applications tab. This takes you to Health e-Blue.
4. Select "Panel – Healthy Blue Living" in the side bar to complete the form.

Billing for the qualification form and exam

BCN will pay primary care providers $40 per member per year for each *Blue Care Network Qualification Form* submitted on Health e-Blue. Providers must file a claim to receive reimbursement for completing the form for members covered by Healthy *Blue* Living or Healthy *Blue* Living HMO Basic℠ and participating in BCN's Wellness Rewards Tracking program. Claims for completing the form should be billed in the amount of $40 using the CPT code *99080. Payment will be reflected on the remittance advice.

Providers must use the appropriate ICD diagnosis code as the primary diagnosis when billing for an initial or subsequent examination. Use ICD-10 code Z00.00 or Z00.01. Additional diagnoses may be billed for specific conditions (for example, high blood pressure). There is no member out-of-pocket cost for the office visit when the primary diagnosis code is Z00.00, or if a preventive medical examination is reported.

Learn more about Healthy *Blue* Living

More information about Healthy *Blue* Living is available within our provider portal by reviewing our supporting documents. These include:

- A provider guide to Healthy *Blue* Living
- A sample *Blue Care Network Qualification Form* that a PCP can use during appointments and pass along to office staff to input online
- Instructions for completing the qualification form on Health e-Blue
- Billing instructions

We're also introducing a new member-facing microsite at **www.bcbsm.com/hbl**, which we encourage providers to pass along to their members for more information.

To find the above resources using Health e-Blue:

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 *Health e-Blue – BCN* on the *Applications* tab.
4. Scroll down to *Resources* and locate the form under the *Healthy Blue Living Supporting Documents* section.

To find the resources on the Provider Resources site of our provider portal:

1. Follow the first two steps above.
2. Click the *Resources* tab.
3. Click *Secure Provider Resources (Blue Cross and BCN)*.
4. Click on the drop-down menu next to *Products* on the menu bar and click *BCN*.
5. Scroll down to 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*.

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Patient Care/ Quality

Reminder: BCN commercial members can receive a physical exam more than once each year

We're frequently asked how often a Blue Care Network commercial (non-Medicare Advantage) member can have a physical examination. BCN has no frequency restrictions for how often a commercial member can receive a physical exam. If a member or their primary care provider deems it necessary, the member is eligible to receive another physical exam. Preventive services are a cornerstone of a health maintenance organization, so BCN wants to encourage and facilitate members in receiving this care.

Here are some examples where a member may receive a physical exam more often than once per year:

- If a member changes primary care providers, the new primary care provider can conduct a physical exam regardless of when the member's last physical was conducted.
- If the physician believes there's a need to conduct a physical exam more often than once per year (for any reason), the physician can ask the member to return for another physical exam.
- If a member has a physical in July and then changes to Healthy *Blue* Living℠ coverage in January and contacts your office for another physical examination in order to get the qualification form completed, it's acceptable to provide another exam, even though it has only been six months since the last exam. The physician can also elect to use the lab results from the July physical to complete the qualification form without conducting another physical exam.

Note: Because of variations in coverage, it's always best to check benefits and eligibility for your patients on 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.

Updated COVID-19 vaccines approved by FDA

The U.S. Food and Drug Administration recently amended the emergency use authorization of COVID-19 vaccines from **Moderna**, **Novavax** and **Pfizer-BioNTech** to include the 2023-24 formula.

Use the following procedure codes for COVID-19 monovalent vaccine administration and products: *90480, *91304, *91318, *91319, *91320, *91321 and *91322.

For more information, see the following:

- **Sept. 14, 2023, *Centers for Medicare & Medicaid Services Medicare Learning Network®* newsletter**
- **Oct. 6, 2023, *CMS MLN* newsletter**

The vaccine administration and products are part of members' preventive benefits. For most health plans, there's no member cost sharing. See below for information about checking vaccine benefits for Blue Cross Blue Shield of Michigan commercial groups that may have cost sharing or may not have vaccine coverage.

Blue Cross commercial groups that may have cost sharing or may not have vaccine coverage

For members who have coverage through Blue Cross commercial groups that are exempt from the Patient Protection and Affordable Care Act, members may have an out-of-pocket cost or they may not have vaccine coverage.

Here's how to check member eligibility and benefits for vaccines:

1. Log in to our provider portal (**availity.com**).
2. Click on *Patient Registration* in the menu bar and then click on *Eligibility and Benefits Inquiry*.
3. Enter the payer information and complete the fields in the *Provider Information* section.
4. Complete the *Patient Information* section and click on *Search*.
5. Select the row for the appropriate member.
6. In the *Service Information* section, enter *Immunizations in the Benefit/Service Type* field.
7. Click on *Submit*.
8. Do one of the following:

If...	Then...
There **is** a *Benefit Explainer* button near the top of the screen	a. Click on the *Benefit Explainer* button. **Tip:** If *Benefit Explainer* doesn't open, you'll need to allow Availity® Essentials to open popups. b. In *Benefit Explainer*, click on the *Search* button. c. Press *CTRL+F*. d. Search *Preventive Immunizations*.
There **isn't** a *Benefit Explainer* button near the top of the screen	a. Press *CTRL+F*. b. Search on *Immunizations*.

For more information, refer to *Blue Cross and BCN are covering additional vaccines*, **Page 29**.

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Learn more about the Cancer Support program for commercial members

In the **November-December 2023 *BCN Provider News***, we reported that Blue Cross Blue Shield of Michigan and Blue Care Network are working with OncoHealth® to provide a Cancer Support program, Iris by OncoHealth. Starting Jan. 1, this program is available to the following adult members (ages 18 and older):

- 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

This program will help adult 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.

For detailed information about the program, see the document titled **Cancer Support program: Frequently asked questions for providers**. Some of the questions that are answered in this document are:

- What's included in the program?
- What if my practice or health system already offers care navigation services to our patients?
- How does Iris get access to a member's medical records?
- How does the Iris team coordinate care with the member's primary care team?
- How do the Iris nurses discuss symptoms and side effects with members?
- What type of mental health support does Iris offer?

To access the FAQ, click the link provided or:

1. Go **bcbsm.com/providers**.
2. Click *Resources* in the top navigation.
3. Click the *View All* link to the right of the *Key forms and documents* heading.
4. Choose *Care management and support services* from the drop-down list.
5. Click the *Cancer Support program FAQ* link.

OncoHealth is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing cancer support 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* in the top navigation.
3. Click the *Search Medical Policies* button.

Medical Policy Updates

Recent updates to the medical policies include:

Covered services

- BMT - Hematopoietic cell transplantation for plasma cell dyscrasias, including multiple myeloma, plasma cell leukemia, plasmacytoma, and POEMS syndrome
- Circulating tumor DNA and circulating tumor cells for selecting targeted therapy for advanced solid cancers (liquid biopsy)
- Coronary computed tomography angiography with selective noninvasive Fractional Flow Reserve (FFRCT)
- Fecal calprotectin
- Gender affirming services
- Identification of microorganisms using nucleic acid probes
- Postsurgical home use of limb compression devices for venous thromboembolism prophylaxis
- Radiofrequency ablation of basivertebral nerve for low back pain (i.e., Intracept)
- Temporomandibular Joint Disorder (TMJ)

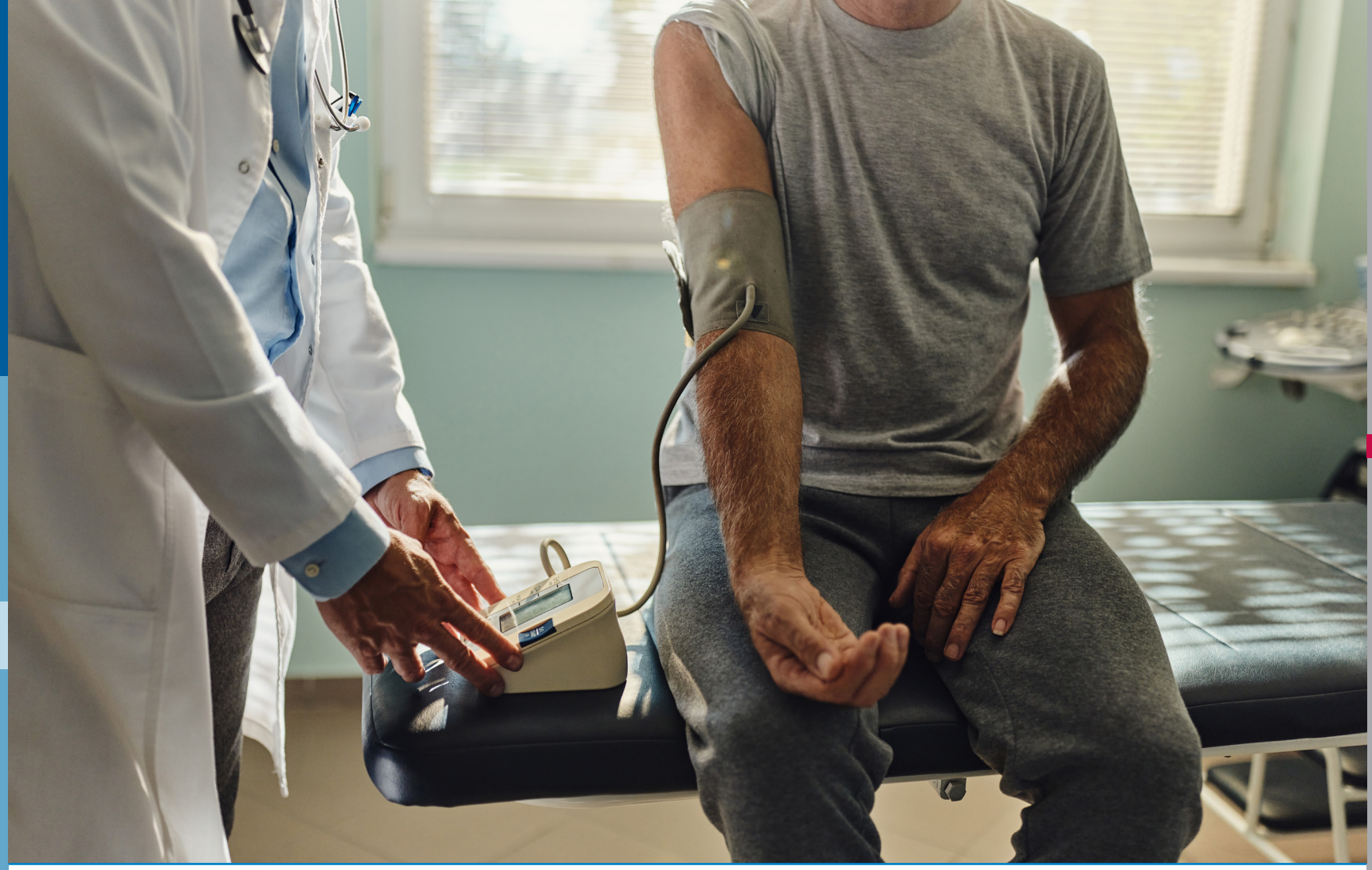
Noncovered services

- In-office needle arthroscopy (e.g., Mi-Eye 2™, Mi-Eye 3 Needlescope™ with Cannula, and VisionScope®)
- Percutaneous ultrasonic ablation as treatment of chronic pain due to tendonitis and fasciitis (Tenex Health TX®)
- Temporarily implanted prostatic stents for benign prostatic hyperplasia (e.g., nitinol device [ITIND], Spanner™)

Established

- Breast reduction for breast-related symptoms
- Genetic testing – NGS of multiple genes (panel) for solid and hematolymphoid malignant conditions
- Percutaneous Electrical Nerve Stimulation (PENS) and Percutaneous Neuromodulation Therapy (PNT), and restorative neurostimulation therapy

Patient Care/ Quality



Here are some other articles in this issue that may be of interest

- *We auto-assign a primary care provider on first day of coverage for certain BCN commercial members,* **Page 4**
- *Update to current Health e-Blue video tutorial training course as well as new mini-lesson video,* **Page 8**
- *Blue Cross and BCN are covering additional vaccines,* **Page 29**

Behavioral Health

Blue Cross encourages medical providers to identify secondary behavioral health issues, refer to a behavioral health provider and follow up post discharge

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

Health care providers play in an intricate part in helping the patients to navigate between inpatient care to outpatient services. Appropriate identification of health issues and proper follow-up care can streamline the process and lessen visits to multiple providers and improve continuity of care for the patient. This is essential for providing our patients and even our own family members with effective and efficient coordinated mental health care.

Many patients who are admitted to the hospital for chronic or acute medical conditions often exhibit certain symptoms that help practitioners identify the health ailment and provide the appropriate testing and interventions. However, what about the symptoms such as sadness and fear that may not easily be recognized or hidden by the physical symptoms? Chronic health conditions and mental health disorders often are concurrent with one another with the latter one being overlooked. Mental health disorders can often go unnoticed until a catastrophic event occurs, such as suicide or mass shooting, which then reveals the severity of the patient's mental health status. According to the National Alliance on Mental Illness approximately 1,469,000 adults in Michigan have a mental health condition (2021). Yet more than half of these individuals didn't receive proper treatment (Reist et al., 2022).

This lack of recognition of mental health disorders for those hospitalized with a medical condition presents as one of the top barriers associated with decreased continuity of care. A recent statistical analysis revealed that out of 12,000 patients admitted to the hospital with a medical condition, only 140 were referred to psychiatry, yielding a referral rate of 1.17% (Pingali et al., 2020). These statistics are concerning because the ultimate goal is early detection of any underlying mental health issue that may be negatively impacting the patient's physical health and impeding daily functioning. Our health plans findings revealed similar numbers as less than 5% of members hospitalized with a new behavioral health diagnosis received proper treatment and follow-up care while hospitalized.

As a result of this lack of identification or follow through during hospitalization, these patients often get released from the hospital without the appropriate mental health follow-up care afterward. The health plans findings revealed that approximately 25% of members didn't receive follow-up post discharge. Follow-up care is important especially for those individuals who have been diagnosed with a new or existing behavioral health concern. We, as health care providers, know that discharge starts once the patient is admitted and discharging patients can be a complex process due to individual circumstances. There are many components to consider when it comes to discharge, such as the ability of patient to care for self, safe place to stay, medication to start with, continuation of those medications, and addressing any follow-up or discharge appointments the

Continued on following page

member may need. We ask ourselves, "Does the patient understand the process, their diagnosis and what is needed after discharge?"

Addressing these issues may not be easy and will definitely not occur overnight; however, there are some actions that can be taken to help mitigate the barriers. As the number of behavioral health specialists continues to decline, medical clinicians are more inclined to identify behavioral health disorders and provide the proper treatment plan. Statistics indicate that approximately 80% of those with a behavioral health disorder will seek treatment from their medical clinicians (Kieu, 2021). Medical clinicians may face more challenges in identifying behavioral health disorders since the symptoms are not as easily identified as medical conditions. More emphasis needs to be placed upon early identification of mental health disorders and ensuring that a complete and thorough health assessment is completed on all patients hospitalized for a medical condition whether or not they exhibit mental health issues. Once it is determined that a mental health issue exists, an inpatient consultation with a behavioral health specialist should be placed so the members' needs are addressed accordingly, and the appropriate treatment plan can be implemented for both inpatient treatment and post discharge follow-up.

Trained professionals should take the opportunity to become more competent with the identification of mental health disorders as they are with medical problems. Asking the appropriate questions and providing patient centered care in a collaborative setting can truly have a significant impact on a patient's overall well-being, and potentially save lives when conditions are managed appropriately with regular follow-up care.

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Reist, C., Petiwala, I., Latimer, J., Borish Raffaelli, S., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. Medicine (Baltimore) 101(52) Retrieved from https://ncbi.nlm.nih.gov.

Reminder: Changes coming to prior authorization, case management functions for behavioral health services in January

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.

We recently communicated these changes in ***BCN Provider News***.

Prior authorization and concurrent review requests will be managed through Blue Cross Behavioral Health℠. Case management services will be handled through Blue Cross Coordinated Care℠. These programs will align and standardize prior authorization and case management functions for members. The changes will affect most members covered by Blue Cross commercial, Medicare Plus Blue℠, BCN commercial and BCN Advantage℠ plans.

Continued on following page

Find details in the FAQ

We updated the **Blue Cross Behavioral Health: Frequently asked questions for providers** document with the latest information. Here are the most recent changes:

- In the "Submitting prior authorization requests and concurrent review requests" section:
  - We outlined how to submit requests electronically and by phone, before and after Jan. 1.
  - We listed the medical necessity criteria we'll use to make determinations on these requests.
- In the "Autism evaluation and treatment changes" section, we added information about:
  - Additional opportunities for members to obtain a comprehensive diagnostic autism evaluation prior to starting treatment
  - How to request a "bridge authorization," which allows members to start applied behavior analysis, or ABA, treatment while they're in the process of completing the components of the comprehensive evaluation
- In the "Appeals" section, we updated the information to show that you should follow the instructions in the determination letter to submit an appeal of a request that wasn't approved.

You can access the FAQ at **ereferrals.bcbsm.com** on the:

- *Blue Cross* ***Behavioral Health*** and ***Autism*** pages
- *BCN* ***Behavioral Health*** and ***Autism*** pages

Here's another article in this issue that may be of interest

- *Virtual Care replacing Blue Cross Online Visits in January*, **Page 13**

Pharmacy News

Starting Jan. 1, 2024, we're changing how we cover some steroid inhaler medications

Starting January 1, 2024, your patients may need a new prescription for their steroid inhaler medication. To avoid disruption in therapy, you can help your patients by prescribing one of the following covered preferred alternatives.

We occasionally review medications to ensure members receive safe, high-quality care that meets their needs.

Drugs that will change on the Preferred Drug List

Affected drugs	Change effective January 1	Covered preferred alternative drugs, starting January 1
• Arnuity Ellipta®	Not covered on drug list	• Asmanex® • Pulmicort Flexhaler®
• Flovent® HFA • Flovent® Diskus®	Discontinued by manufacturer	

Drugs that will change on the Clinical, Custom and Custom Select Drug Lists

Affected drugs	Change effective January 1	Covered preferred alternative drugs, starting January 1
• QVAR®	Not covered on drug list	• Arnuity Ellipta® • Asmanex® • Pulmicort Flexhaler®
• Flovent® HFA • Flovent® Diskus®	Discontinued by manufacturer	

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

We've updated how we calculate MME measurements for certain opioids

Blue Cross Blue Shield of Michigan and Blue Care Network have updated how we calculate morphine milligram equivalents, or MME, measurements for certain opioids. The update, based on changes recommended by the Centers for Disease Control and Prevention, was effective Oct. 1.

MMEs are calculations used to measure and compare different opioids, using morphine as the standard. Blue Cross requires a prior authorization for opioid dosages that exceed 90 MMEs per day. This change will only affect the opioids listed in the table below:

Medication	Current MME conversion factor	New MME conversion factor
Hydromorphone	4	5
Methadone	Sliding scale dependent on dose	4.7
Tramadol	0.1	0.2

Members who fill hydromorphone, methadone or tramadol prescriptions may experience a claim rejection when their total daily MME exceeds the plan threshold level of 90 MME, even if the member hasn't changed doses. The total MME of all opioids remains at 90 MME per day and won't change.

If the pharmacy receives a rejected claim due to this change, the provider will need to submit a prior authorization request attesting that the dose is medically necessary. If we don't provide a prior authorization, members may not be able to fill the prescribed dose.

For more information related to this change, refer to the **Opioid National Drug Code and Oral MME Conversion File Update** on the CDC website.

Tecvayli will have additional requirements for most commercial members, starting Dec. 7

Blue Cross Blue Shield of Michigan and Blue Care Network are updating the medical policy for Tecvayli® (teclistamab-cqyv), HCPCS code J9380. The requirements in the updated medical policy will apply for most Blue Cross and BCN commercial members for dates of service on or after Dec. 7, 2023.

In keeping with the updated medical policy, members will have to meet the following additional requirements for treatment with Tecvayli to be considered medically necessary:

- Alanine aminotransferase, or ALT, and aspartate aminotransferase, or AST, less than or equal to three times the upper limit of normal, or ULN
- Creatinine clearance greater than or equal to 40 mL/min
- Left ventricular ejection fraction greater than or equal to 40%
- No active autoimmune disease except vitiligo, Type 1 diabetes mellitus or prior autoimmune thyroiditis

You can see the full list of requirements in the updated medical policy, which will be available by Dec. 7. To view the policy, go to the **Medical Policy Router Search** page, enter the name of the drug in the *Policy/Topic Keyword* field and press *Enter*. The search results will include links to both the current medical policy and the updated medical policy.

Note: To access the *Medical Policy Router Search* page, go to **bcbsm.com/providers**, click on *Resources* and then click on *Search Medical Policies*.

Some Blue Cross commercial groups aren't 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.

Additional information

For additional information about drugs covered under the medical benefit, see the following pages of the **ereferrals.bcbsm.com** website:

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

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

Vyvgart Hytrulo to have a site-of-care requirement for most commercial members, starting Jan. 1

For dates of service on or after Jan. 1, 2024, 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:

- Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), 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 Vyvgart Hytrulo 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 Vyvgart Hytrulo before Jan. 1, 2024, 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 the effective date.

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

- **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.

Pharmacy News

Beyfortus to have quantity limits for commercial members, starting Jan. 1

Starting Jan. 1, 2024, Beyfortus™ (nirsevimab-alip), procedure codes *90380 and *90381, will have quantity limits when billed under the pharmacy benefit. There won't be quantity limits when Beyfortus is billed under the medical benefit.

Note: For the administration of Beyfortus, use procedure codes *96380 and *96381.

Administration site and coverage details

Beyfortus is covered as follows:

Administration site	How it's covered
Health care provider's office	Under the **medical** benefit, with no quantity limits
Retail pharmacy when **the member has pharmacy benefits through Blue Cross Blue Shield of Michigan or Blue Care Network**	Under the **pharmacy** benefit Quantity limits will apply
Retail pharmacy when **both** of the following are true: • The member **doesn't** have pharmacy benefits through Blue Cross or BCN. • The pharmacy participates in the Blue Cross Vaccine Affiliation Program.	Under the **medical** benefit, with no quantity limits

Continued on following page

Blue Cross commercial groups that may have cost sharing or may not have vaccine coverage

For members who have coverage through Blue Cross Blue Shield of Michigan commercial groups that are exempt from the Patient Protection and Affordable Care Act, members may have an out-of-pocket cost or they may not have vaccine coverage.

Here's how to check member eligibility and benefits for vaccines:

1. Log in to our provider portal (**availity.com**).
2. Click on *Patient Registration* in the menu bar and then click on *Eligibility and Benefits Inquiry*.
3. Enter the payer information and complete the fields in the *Provider Information section*.
4. Complete the *Patient Information* section and click on *Search*.
5. Select the row for the appropriate member.
6. In the *Service Information* section, enter *Immunizations* in the *Benefit/Service Type* field.
7. Click on Submit.
8. Do one of the following:

If...	Then...
There **is** a *Benefit Explainer* button near the top of the screen	a. Click on the *Benefit Explainer* button. **Tip:** If *Benefit Explainer* doesn't open, you'll need to allow Availity® Essentials to open popups. b. In *Benefit Explainer*, click on the *Search* button. c. Press *CTRL+F*. d. Search *Preventive Immunizations*.
There **isn't** a *Benefit Explainer* button near the top of the screen	a. Press *CTRL+F*. b. Search on *Immunizations*.

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.

Blue Cross and BCN are covering additional vaccines

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

Vaccine	Common name and abbreviation	Effective date
Beyfortus™	Respiratory syncytial virus (RSV)	Sept. 28, 2023

Continued on following page

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

Vaccines that have an age requirement

Vaccine	Common name and abbreviation	Age requirement
Gardasil 9®	Human papillomavirus vaccine (HPV)	9 to 45 years old
Influenza virus	Influenza vaccine (Flu)	• Under 9: 2 vaccines per 180 days • 9 and older: 1 vaccine per 180 days
Prevnar 13®	Pneumococcal 13 - valent conjugate vaccine	9 to 45 years old

Vaccines that 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

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Vaccine	Common name and abbreviation
• 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
• Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine (PPSV23)
• IPOL®	Poliovirus (IPV)
• Arexvy™ • Abrysvo™ • Beyfortus™	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) (chickenpox)
• Shingrix®	Zoster vaccine (RZV) (Shingles)

Covid vaccines
• Pfizer COVID-19 vaccine (2023-2024), 6 months to 4 years old
• Pfizer COVID-19 vaccine (2023-2024), 5 to 11 years old
• Comirnaty, Pfizer COVID-19 vaccine (2023-2024)
• Spikevax, Moderna COVID-19 vaccine (2023-2024)
• Novavax COVID-19 vaccine (2023-2024)

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

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

Syfovre and Izervay must not be used with other geographic atrophy drugs for commercial members

For dates of service on or after Nov. 24, 2023, the following drugs must not be used in combination with each other or any other geographic atrophy, or GA, drug:

- Syfovre® (pegcetacoplan), HCPCS codes J3490 and C9151
- Izervay™ (avacincaptad pegol), HCPCS code J3590

This change affects Blue Cross Blue Shield of Michigan commercial members and Blue Care Network commercial members.

Syfovre and Izervay will continue to require prior authorization through the NovoLogix® online tool as specified in the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**.

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.

Additional information

For additional information about drugs covered under the medical benefit, see the following pages of the **ereferrals.bcbsm.com website**:

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

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

Pharmacy News

Changes coming to preferred drug designations under medical benefit for most commercial members

For dates of service on or after Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network are making changes to preferred drug designations for some products. In addition, providers will need to submit prior authorization requests through different systems for some preferred and nonpreferred drugs.

These changes will affect:

- Most Blue Cross commercial members

  Exception: These changes don't apply to UAW Retiree Medical Benefits Trust non-Medicare members or Blue Cross and Blue Shield Federal Employee Program® members.
- All BCN commercial members

Changes to preferred drug designations

We're changing preferred drug designations as shown in the following table. Changes are in **bold text**.

Product	Preferred drugs	
	Before Jan. 1, 2024	On or after Jan. 1, 2024
Bevacizumab	• Mvasi® • Zirabev®	• **Mvasi only**
Pegfilgrastim	• Fulphila • Neulasta®, Neulasta® OnPro® • Ziextenzo®	• Neulasta, Neulasta OnPro • **Nyvepria®**
Rituximab	• Riabni™ • Ruxience®	• Ruxience • **Truxima®**
Trastuzumab	• Kanjinti® • Trazimera®	• Kanjinti • **Ogivri®**

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How existing prior authorizations are affected by these changes

Existing prior authorizations are affected as follows:

- For bevacizumab, rituximab and trastuzumab products, the member can continue taking a drug that will be designated as nonpreferred after Jan. 1 until their existing authorization expires. However, we encourage health care providers to begin using products that will be designated as preferred starting Jan. 1, 2024.
- For pegfilgrastim products, active authorizations for Fulphila and Ziextenzo will end Dec. 31, 2023. Providers will need to transition members who are currently taking Fulphila or Ziextenzo to a preferred drug for dates of service on or after Jan. 1, 2024.

Changes to prior authorization processes

The following table outlines prior authorization requirements for the drugs listed above for dates of service on or after Jan. 1, 2024.

To determine which Blue Cross commercial groups have opted in to the Carelon medical oncology program, see the **Carelon medical oncology prior authorization program opt-in list for Blue Cross commercial self-funded groups**.

Lines of business	Changes to requirements
• BCN commercial members • Blue Cross commercial members whose groups participate in the Carelon medical oncology program	• Preferred drugs will require prior authorization through Carelon Medical Benefits Management. **Exception:** Rituximab preferred drugs won't require prior authorization. • Nonpreferred drugs will require prior authorization through the NovoLogix® online tool.
Blue Cross commercial members whose groups don't participate in the Carelon medical oncology program	• Preferred products won't require prior authorization. • Nonpreferred products will require prior authorization through NovoLogix.

Additional information

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

- **Medical oncology prior authorization list for Blue Cross and BCN commercial members**
- **Blue Cross and BCN utilization management medical drug list**

For additional information about medical benefit drugs, see the following pages of our **ereferrals.bcbsm.com** website:

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

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

Changes to preferred drug designations and prior authorization requirements for Medicare Advantage members

For dates of service on or after Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network are making changes to the preferred and nonpreferred designations for some medical benefit drugs.

In addition, health care providers will need to submit prior authorization requests through different systems for some preferred and nonpreferred drugs.

These changes will affect most Medicare Plus Blue℠ members and BCN Advantage℠ members.

Preferred drug designations are changing

Starting Jan. 1, we're changing preferred drug designations as shown in the following table. Changes are in **bold text**.

Reference product	Preferred drugs	
	Before Jan. 1, 2024	On or after Jan. 1, 2024
Bevacizumab	• Mvasi®, HCPCS code Q5107 • Zirabev®, HCPCS code Q5118	• Mvasi, HCPCS code Q5107
Infliximab	• Avsola®, HCPCS code Q5121 • Inflectra®, HCPCS code Q5103	• Avsola, HCPCS code Q5121 • **Renflexis**®, HCPCS code Q5104

Continued on following page

Reference product	Preferred drugs	
	Before Jan. 1, 2024	On or after Jan. 1, 2024
Pegfilgrastim	• Fulphila, HCPCS code Q5108 • Neulasta®, Neulasta® OnPro®, HCPCS code J2506 • Ziextenzo®, HCPCS code Q5120	• Neulasta, Neulasta OnPro, HCPCS code J2506 • **Nyvepria**®, HCPCS code Q5122
Rituximab	• Riabni™, HCPCS code Q5123 • Ruxience®, HCPCS code Q5119	• Ruxience, HCPCS code Q5119 • **Truxima**®, HCPCS code Q5115
Trastuzumab	• Kanjinti®, HCPCS code Q5117 • Trazimera®, HCPCS code Q5116	• Kanjinti, HCPCS code Q5117 • **Ogivri**®, HCPCS code Q5114

How to submit prior authorization requests

Submit prior authorization requests as follows:

- Preferred oncology drugs will require prior authorization through Carelon Medical Benefits Management. All other preferred drugs will require prior authorization through the NovoLogix® online tool.
- Nonpreferred drugs will require prior authorization through NovoLogix.

Note: Preferred infliximab and rituximab agents don't require prior authorization.

Reminder: Bevacizumab agents don't require prior authorization for use in retinal disorders.

To submit a prior authorization request, log in to our provider portal (availity.com), click on *Payer Spaces* in the menu bar and then click on the BCBSM and BCN logo. Then click on the tile to access the appropriate NovoLogix tool or the Carelon ProviderPortal.

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

When prior authorization is required

These drugs will require prior authorization when they're administered by a health care provider in sites of care such as outpatient facilities or physician 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 using the *UB04 claim* form for a hospital outpatient type of bill 013x

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 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 and electronic data interchange 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. For more information, go to our ereferrals.bcbsm.com website.

Changes coming to infliximab step therapy requirements for Medicare Advantage members in January

For dates of service on or after Jan. 1, 2024, infliximab step therapy requirements are changing for Cimzia®, Skyrizi® IV and Ilumya®. These changes apply to Medicare Plus Blue℠ and BCN Advantage℠ members.

Notes:

- These drugs are part of members' medical benefits, not their pharmacy benefits.
- These drugs require prior authorization. Submit requests through the NovoLogix® online tool.

Requirements added for Cimzia and Skyrizi

Starting Jan. 1, members will have to try and fail a preferred infliximab drug before a health care provider requests prior authorization for the following drugs:

- Cimzia (certolizumab pegol), HCPCS code J0717
- Skyrizi IV (risankizumab-rzaa), HCPCS code J2327

For information about preferred drug designations, see our provider alert, **Update: Changes to preferred drug designations and prior authorization requirements for Medicare Advantage members**.

Requirements removed for Ilumya

Starting Jan. 1, members won't have to try and fail a preferred infliximab drug before using Ilumya.

Ilumya will continue to require prior authorization.

How to submit prior authorization requests

To submit a prior authorization request, log in to our provider portal, **availity.com**, click on Payer Spaces in the menu bar and then click on the BCBSM and BCN logo. Then click on the tile to access the appropriate NovoLogix tool.

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

When prior authorization is required

The drugs mentioned above require prior authorization when they are administered by a provider in sites of care such as outpatient facilities or physician 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 using the *UB04 claim* form for a hospital outpatient type of bill 013x

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 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 and electronic data interchange services.

Billing Bulletin

Know guidelines for trauma activation billing and reimbursement

Blue Cross Blue Shield of Michigan and Blue Care Network follow the National Uniform Billing Committee rules for billing and reimbursing trauma activation charges. Effective immediately, Blue Cross and BCN won't reimburse providers for trauma activation charges when they're billed outside of the NUBC guidelines on inpatient facility claims. This rule applies to all claims submitted for Blue Cross commercial and BCN commercial members.

This reimbursement policy isn't intended to affect patient care. Health care providers are expected to apply medical judgment when caring for all members.

Here's how to bill trauma activation under NUBC guidelines:

- Use revenue code 068x in conjunction with FL 14, Type of Admission/Visit code 05. In the event of trauma activation, the facility must have received a prearrival notification from a prehospital caregiver, such as a paramedic or other emergency medical services provider.
- If the member wasn't assigned a prehospital notification revenue code, 068X shouldn't be billed. However, the member may be classified as experiencing trauma on the UB-04, using FL 14, Type of Admission/Visit code 05 when identifying the member for follow-up purposes.
- Non-designated trauma centers shouldn't use FL 14, type 5 or 068X when billing for trauma services.

In addition to NUBC guidance for appropriately billing trauma activation, there's also trauma activation criteria set forth by the American College of Surgeons. Apply the ACS criteria in the prehospital setting to identify trauma patients who would benefit most from the highest level of trauma activation.

The minimum criteria to activate the highest level of trauma activation is based on ACS 2022 updates to **Resources for Optimal Care of the Injured Patient**. It includes one or more of the following:

- Confirmed blood pressure less than 90 mm hg at any time in adults, and age-specific hypotension in children
- Gunshot wounds to the neck, chest or abdomen

Continued on following page

- Glasgow Coma Scale less than 9, with mechanism attributed to trauma
- Transfer patients from another hospital who require ongoing blood transfusion
- Patients intubated in the field and directly transported to a trauma center
- Patients who have respiratory compromise or need an emergent airway
- Transfer patients from another hospital with ongoing respiratory compromise (excludes patients intubated at another facility who are now stable from a respiratory standpoint)
- Patients experiencing an emergency as determined by a physician

Revenue code 068X is **only** permitted for reporting trauma activation charges, and trauma centers and hospitals must be licensed, designated or authorized by the state. The revenue code a facility may bill is determined by the ACS designation. See table below for details:

Revenue code	Description
0681	Trauma Center Level 1
0682	Trauma Center Level II
0683	Trauma Center Level III
0684	Trauma Center Level IV
0689	Extend beyond Level IV, assigned by state or local authorities

Clarification: Blue Cross updating reimbursement policy for administering blood transfusions at inpatient facilities

Blue Cross Blue Shield of Michigan and Blue Care Network will no longer reimburse health care providers for administering blood transfusions on inpatient facility claims, effective Feb. 1, 2024.

This policy applies to all inpatient facility claims submitted for Blue Cross and BCN commercial members.

A blood transfusion is a routine medical procedure generally administered by nursing staff. Nursing services should be included in the general cost of the room where services are being given; therefore, this service is considered ineligible for separate reimbursement.

When billing blood administration on a *UB-04* for inpatient services, use the correct revenue code 0391.

Additional information

A blood transfusion is prescribed by a physician or a nonphysician practitioner for many reasons, including, but not limited to, surgery, injury and bleeding disorders.

Our updated reimbursement policy isn't intended to affect decision-making for patient care, and health care providers are expected to apply medical judgment when caring for all members.

Billing Bulletin

Blue Cross doesn't reimburse providers for bladder scanning

Blue Cross Blue Shield of Michigan and Blue Care Network won't reimburse providers for performing bladder scans on inpatient facility claims. This reimbursement policy isn't intended to impact decision-making for care of the patient, and providers are expected to apply medical judgement when caring for all members. This policy applies to all inpatient facility claims submitted for Blue Cross commercial and Blue Care Network commercial members.

Background

Bladder scanning is a routine non-invasive test generally performed by nursing staff or nurse's aide and is prescribed by a physician or a nonphysician practitioner. Nursing services should be included in the general cost of the room where services are being rendered; therefore, this service is considered not eligible for separate reimbursement.

Additional features now available for uploading medical records electronically

Blue Cross Blue Shield of Michigan and Blue Care Network have recently added functionality that enables providers to receive requests for medical records through our provider portal, Availity® Essentials.

Starting Dec. 19, 2023, providers are now able to set up our provider portal to receive requests for medical records through the Claims Attachment dashboard. After doing this, providers will be able to upload medical records through the Attachments dashboard.

We'll send these requests when we need medical records to help us adjudicate claims or decide on appeals. For Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members, this functionality is available for claims, for appeals or for both.

We've also updated the **Submitting medical records through Availity Essentials** document with information about setting up our provider portal to receive these requests and using the new method to upload medical records.

Register for a webinar about the new functionality

There will be a training webinar on Jan. 9, 2024, to demonstrate how to set up and use the new functionality. Follow these steps to register for the webinar.

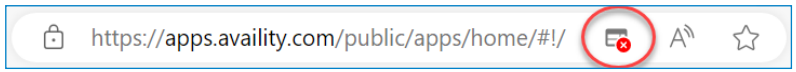
1. Log in to our provider portal (**availity.com**)

   Important: You must be logged in to Availity Essentials for the links to direct you to the registration page.

2. Click on the link below to register.

   - **Jan. 9, 2024 (2 to 3 p.m. Eastern time)**

If the enrollment page doesn't open, you'll need to allow popups from **availity.com**. To do this, click the popup blocker icon in your internet browser's address bar.



If you're unable to attend the live webinar, a recoding of the Dec.14, 2023 webinar will be available starting Dec. 20. To access the recorded webinar:

1. Log in to our provider portal (**availity.com**).
2. Click *Help & Training* in the top navigation and then click *Get Trained*.
3. Click the *Search* field at the top of the screen.
4. In the *Search* field, enter BCBSM and then click *Catalog*.

5. Click the appropriate link to access the recorded training.

Reasons to upload medical records electronically

We encourage providers to upload medical records through Availity Essentials because:

- It's more secure than submitting by fax or mail, which is important since medical records include protected health information.
- It avoids the limitations of faxing.
- It reduces manual effort.

What if I don't want to use this new functionality

For providers who don't want to receive these requests through our provider portal:

- We'll continue to send medical record requests as we do currently.
- We'll continue to accept paper and fax submission of medical records.
- Providers can continue to submit medical records by going to the Claim Status screen, locating the claims for which they want to submit medical records and clicking *Send Attachments*. This process is outlined in the document titled *Submitting medical records through Availity Essentials*.

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Additional information

Here's how you can access the *Submitting medical records through Availity Essentials* document:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then clicking the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources* (*Blue Cross and BCN*).
5. Click the *Billing and Claims* menu and then click *Claims*.
6. Click the *Submitting medical records through Availity Essentials (PDF)* link.

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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.

Clinical Editing Billing Tips

This issue's tips:

- Clinical editing appeal reminders
- Not reporting modifiers will impact the outcome of an appeal
- Appealing unlisted procedures

Here are some other articles in this issue that may be of interest

- *Reminder: BCN commercial members can receive a physical exam more than once each year,* **Page 16**
- *Blue Care Network fee schedule update reminder,* **Page 9**

Referral Roundup

For commercial LTACH requests, questionnaire opens in e-referral system

When submitting a prior authorization request for an admission to a long-term acute care hospital, or LTACH, you must complete a questionnaire about the three skilled nursing facilities, or SNFs, you have contacted.

These must be SNFs you believe may be able to provide care for the member but that have indicated they can't provide the level of care the member requires.

This applies to LTACH placement requests for most Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

You must provide the following information:

- Whether you've contacted three SNFs (yes or no)
- Name and contact information for each SNF

Follow the prompts in the questionnaire to ensure you've provided the information that's required.

If the required information 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.

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, such as complex wound care or total parenteral nutrition.

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 Prior Authorization**
- **BCN Prior Authorization and Plan Notification**

We'll use updated 2023 InterQual criteria, starting Feb. 1

On Feb. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will start using updated 2023 InterQual® criteria to make determinations on prior authorization requests for the services we manage.

Change Healthcare published updates to its 2023 InterQual criteria on Oct. 6, 2023. Refer to the table below to see which updated criteria we're adopting. When you open the documents linked below, you'll see the changes in red.

Criteria	Services
InterQual acute — Adult	• Inpatient admissions • Continued stay discharge readiness
InterQual acute — Pediatric	• 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 discharge readiness

How we'll use the updated criteria

We'll use the updated criteria to make determinations on prior authorization requests for non-behavioral health services for the following members:

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

When clinical information is requested for a medical or surgical admission or for other services, we require providers to submit 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.

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
- Doesn't apply to behavioral health services

No updates to our local rules

We're not updating our local rules. We use InterQual criteria and our local rules when making determinations on prior authorization requests for Blue Cross and BCN commercial members for these types of post-acute care:

- Skilled nursing
- Inpatient rehabilitation
- Long-term acute care

You can access the local rules for post-acute care as follows:

- On the **Blue Cross Prior Authorization** page of **ereferrals.bcbsm.com**. Look in both the Blue Cross commercial and the Medicare Plus Blue sections of that page.
- On the **BCN Prior Authorization and Plan Notification** page of **ereferrals.bcbsm.com**. Look under the *Referral and authorization information* heading.

Facilities must submit appeals within required time frames

What you need to know

- We reinstated the time frames for submitting appeals for nonapproved prior authorization requests on July 1, after waiving those time frames during the COVID-19 public health emergency.
- The time frames for Level One and Level Two appeals are highlighted in the chart below.
- You can find more information in our provider manuals.

Facilities must submit appeals of nonapproved inpatient medical and surgical (non-behavioral health) prior authorization requests within the time frames stated in the denial letters.

We reinstated the usual appeals time frames on July 1

During the COVID-19 public health emergency, Blue Cross Blue Shield of Michigan and Blue Care Network waived the time frames for submitting appeals. We reinstated the time frames for submitting appeals, starting July 1, 2023. This was communicated in a **May 1, 2023, provider alert**.

Time frames for submitting appeals

Here are the time frames for submitting appeals of inpatient medical and surgical (non behavioral health) prior authorization requests that we've denied:

- For initial denial decisions made before July 1, 2023, we'll stop accepting appeals on Jan. 1, 2024.
- For initial denial decisions made on or after July 1, 2023, the usual time frames for appeals apply:

Plan	How it works
Blue Cross commercial	• A Level One appeal must be submitted within 45 days of the date on the original denial letter. Appeals submitted after the 45th day won't be accepted. • A Level Two appeal must be submitted within 20 days of the date on the Level One appeal denial letter. Appeals submitted after the 20th day won't be accepted.
• Medicare Plus Blue℠ • BCN commercial • BCN Advantage℠	• A Level One appeal must be submitted within 45 days of the date on the original denial letter. • A Level Two appeal must be submitted within 21 days of the date on the Level One appeal denial letter. • If a Level One appeal is submitted after the 45th day but by the 66th day, it will be processed as a Level Two appeal. • Appeals received more than 66 days after the date on the original denial letter won't be accepted.

Continued on following page

Where to find additional information

For additional information about submitting appeals of prior authorization requests that aren't approved, refer to the pertinent provider manual:

- Blue Cross commercial: Refer to the "Preapproval of Services" chapter. Look in the section titled "Appealing a prior authorization decision."
- Medicare Plus Blue: In the ***Medicare Plus Blue PPO Provider Manual***, look in the section titled "Appealing Medicare Plus Blue's Decision."
- BCN commercial and BCN Advantage: Refer to these two chapters in the *BCN Provider Manual*:
  - In the **"BCN Advantage" chapter**, look in the section titled "BCN Advantage provider appeals."
  - In the **"Utilization Management" chapter**, look in the section titled "Appealing utilization management decisions."

To access the provider manuals:

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

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Changes to prior authorization request process for varicose vein procedures

Due to changes to our *Treatment of varicose veins/venous insufficiency* medical policy, we've changed the prior authorization process for varicose vein procedures.

Keep reading to learn more.

Questions presented in e-referral system

In late November, we removed the following questionnaires from the e-referral system:

- *Endovenous ablation for treatment of varicose veins*

  This questionnaire opened for Medicare Plus Blue, Blue Care Network commercial and BCN Advantage members for procedure codes *36473, *36474, *36482 and *36483.

- *Varicose vein treatment*

  This questionnaire opened for BCN commercial and BCN Advantage members for procedure codes *36465, *36466, *36470, *36471, *36475, *36476, *36478, *36479, *37718, *37700, *37722, *37780, *37785, *37799 and S2202.

Instead of completing a questionnaire, the e-referral system now prompts you to answer a series of questions when submitting prior authorization requests. Here are the details:

- For procedure codes *36473, *36474, *36482, the e-referral system displays questions when submitting requests for Medicare Plus Blue, BCN commercial and BCN Advantage members.

Continued on following page

- For procedure codes *36465, *36466, *36470, *36471, *36475, *36478, *37718, *37700, *37722, *37780, *37785 and S2202, the e-referral system displays questions for BCN commercial and BCN Advantage members.

  Note: Procedure code *37799 will continue to require prior authorization. Although you won't be prompted to answer a series of questions when submitting prior authorization requests, you will have to complete the *Experimental and investigational services questionnaire*.

As before, the e-referral system will either auto-approve or pend the request depending on your answers to the questions. For pended requests, you'll need to submit additional clinical documentation.

How to access the updated medical policy

To view the updated medical policy:

1. Go to **bcbsm.com/providers**.
2. Click *Resources* in the top navigation.
3. Click the *Search Medical Policies* button.
4. Enter *Treatment of varicose veins/venous insufficiency* in the Policy/Topic Keyword field.
5. In the search results, click the link to open the medical policy.

This policy includes requirements for endovenous ablation for the treatment of varicose veins.

New and updated questionnaires in e-referral system

On Nov. 5, 2023, Blue Care Network added and updated questionnaires in the e-referral system. We also added and updated the corresponding preview questionnaires on the **ereferrals.bcbsm.com** website.

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

New questionnaires

We added the following questionnaires to the e-referral system:

Questionnaire	Opens for	Details
Computed tomography to detect coronary artery calcification trigger	BCN commercial	Opens for procedure code *75571.
Computed tomography to detect coronary artery calcification	BCN commercial	Opens for procedure codes *75571 and S8092.

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Updated questionnaires

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

Questionnaire	Opens for	Details
Bone-anchored hearing aid	BCN commercial BCN Advantage	Opens for procedure codes *69729 and *69730. **Note:** The questionnaire will continue to open for procedure codes *69714, *69716, *69717 and *69719.
Breast implant management	BCN commercial	Updated several questions. **Note:** There were no changes to the *Breast implant management* questionnaire for BCN Advantage members.

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 find the preview questionnaires, go to **ereferrals.bcbsm.com**, click *BCN* and then click **Prior Authorization and Plan Notification**. Scroll down and look under the *Authorization criteria and preview questionnaires* heading.

Authorization criteria and medical policies

The Authorization Requirements & Criteria page explains how to access the pertinent authorization criteria and medical policies.

Solid organ and bone marrow transplants won't require prior authorization for BCN Advantage members, starting Jan. 1

Before Jan. 1, 2024, solid organ and bone marrow transplants, including evaluations and harvesting, require prior authorization through Blue Cross Blue Shield of Michigan and Blue Care Network's Human Organ Transplant program.

For dates of service on or after Jan. 1, 2024, the following transplant procedures won't require prior authorization for BCN Advantage members:

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung
- Lung(s)
- Pancreas
- Partial liver

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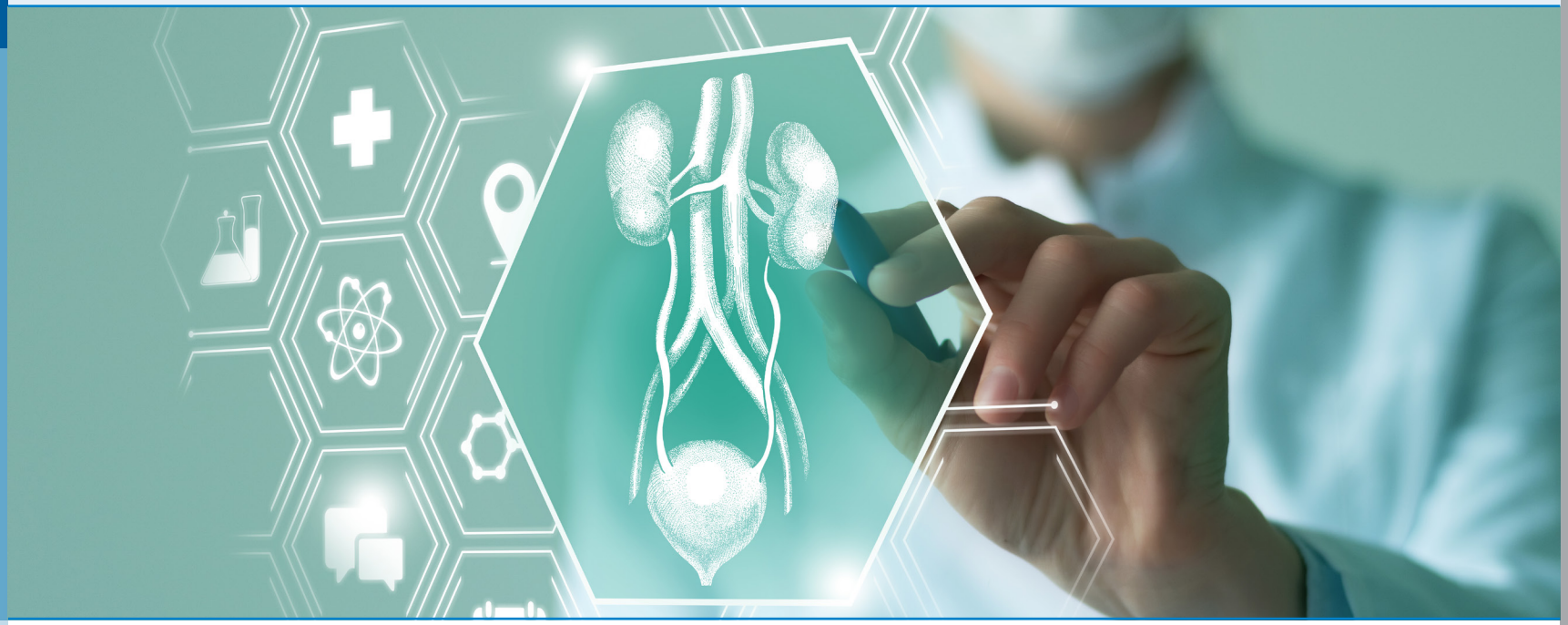
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by BCN)

We'll update our communications to reflect this change before Jan. 1.

Note: In recent issues of *BCN Provider News*, we announced that kidney-only transplants would require prior authorization starting Jan. 1. Due to the change discussed above, kidney-only transplants won't require prior authorization for BCN Advantage members, starting Jan. 1.



Reminder: Kidney-only transplants require prior authorization through the Human Organ Transplant Program

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. This requirement applies to:

- Blue Cross Blue Shield of Michigan fully insured group and individual commercial members
- Blue Care Network fully insured group and individual commercial members

For full details, see the provider alert titled **Update: Kidney-only transplants to require prior authorization through the Human Organ Transplant Program, starting Jan. 1**.

Referral Roundup

When reviewing inpatient admission requests, we'll continue to follow CMS guidelines and evidence-based criteria

For our Medicare Plus Blue℠ and BCN Advantage℠ members, Blue Cross Blue Shield of Michigan and Blue Care Network we will continue to use InterQual®, LOCUS, CALOCUS, ECSII, ASAM criteria and our internal coverage criteria, along with applicable Medicare coverage guidelines, to evaluate hospital admissions when making medical necessity determinations for requests for prior authorization.

According to Medicare coverage guidelines, there are three conditions that require reimbursement for hospital-based services.

1. Two-midnight benchmark
2. Inpatient admission for a surgical procedure specified by Medicare as inpatient only (CMS IPO List)
3. Case by Case exception

   The admitting physician expects the patient to require care only for a limited time that does not cross two midnights.

The 2024 CMS Medicare Advantage Final Rule provided guidance to Medicare Advantage plans regarding the presumption of validity of hospital admissions crossing two midnights and the application of internal coverage criteria to requests for authorization for such hospital admissions. That guidance states:

The two-midnight benchmark: states that a patient is generally appropriate for hospital level of care if the patient meets two qualifications.

1. The admitting physician expects the patient to require a medically necessary hospital care spanning two or more midnights.
2. The expectation is **supported by the medical record clinical documentation of the members severity of illness and intensity of services required**.

The two-midnight presumption: is an instruction given to the Medicare Administrative Contractor (MAC) which states if the hospital stay spans 2 or more midnights the hospital

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Referral Roundup

care is reasonable and necessary and thus will not select for review unless there is evidence of abuse or delays in the provision of care to qualify for the 2-midnight presumption. The provider is given the benefit of doubt that these admissions meet medical necessity.

The CMS 2024 Medicare Advantage **Final Rule** states the two-midnight presumption doesn't apply to Medicare Advantage Plans, Medicare Advantage plans may conduct prior authorization, concurrent and retrospective reviews, using internal coverage criteria, on hospital stays of any length to consistently interpret medical necessity, including the two-midnight rule. This means provider's decision and clinical documentation must support and be substantiated in the medical record to demonstrate the medical necessity of hospital care regardless of the total time spent in the facility. See **federalregister.gov/documents/2023/04/12/2023-07115** for more information.

BCBSM and BCN will review prior authorization requests for inpatient admissions for the following based on CMS 2024 Final Rule:

- Less than two-midnight hospital admission

  We'll review such requests following the CMS case-by-case exception and apply the evidence-based factors as part of our internal coverage criteria to ensure the complex medical factors documented in the record support the medical necessity of hospital level of care. If the internal coverage criteria are not met at an acute, intermediate, or critical level of care status, the authorization request will be reviewed by Blue Cross medical director to determine medical necessity extending beyond the applicable internal coverage criteria.

- Two-midnight admission

  We'll review such requests applying evidence-based factors as part of our internal coverage criteria to ensure the complex medical factors documented in the medical record support the medical necessity of the hospital level of care. If the internal coverage criteria are not met at an acute, intermediate, or critical level of care status, the authorization request will be reviewed by Blue Cross medical director to determine medical necessity extending beyond applicable evidence-based criteria

- Greater than two-midnight admission

  We'll review such requests applying evidence-based factors as part of our internal coverage criteria and the Medicare coverage guidelines to ensure the complex medical factors documented in the medical record support the medical necessity of the hospital level of care for acute, intermediate, or critical level of care status. If criteria are not met the authorization request will be reviewed by the Blue Cross medical director to determine medical necessity extending beyond the applicable evidence-based criteria.

Note: Hospital care per CMS and under the two-midnight benchmark includes observation level of care. Blue Cross does not perform prior authorization, concurrent or retrospective review for observation level of care. If hospital care meets observation criteria, then the facility should bill appropriately for the level of care.

In this communication, we're reaffirming that:

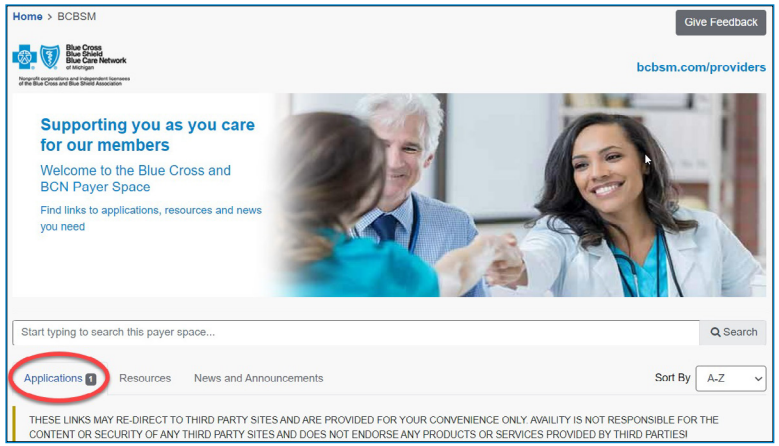
- Blue Cross and BCN will continue to use applicable evidence-based medical necessity criteria as part of our internal coverage criteria and Medicare coverage guidelines to make determinations on prior authorization requests for hospital admissions of our Medicare Advantage members.
- We require admitting physicians and facilities to:
  - Evaluate and document that their expectation of two or more midnights of medically necessary hospital care is reasonable and can be supported by documented medical evidence as required by CMS coverage guidelines.
  - Submit medical documentation that supports the necessity of an hospital admission.

For additional information, see this CMS document: **Fact Sheet: 2024 Medicare Advantage Final Rule (CMS 4201-F)**.

Reminder: How to check the status of prior authorization requests to share with your patients

As a reminder, if a patient who has coverage through Blue Cross Blue Shield of Michigan or Blue Care Network asks about the status of a prior authorization request, you can check it for them by following these steps:

1. Logging in to our provider portal (**availity.com**).
2. Clicking *Payer Spaces* in the menu bar and then clicking the BCBSM and BCN logo.
3. Clicking the applicable tile in the *Applications* tab through which you submitted the authorization request.



Additional information available for providers

Providers can also find a summary of services that require prior authorization through our **Summary of utilization management programs for Michigan providers** document on **ereferrals.bcbsm.com**.

Note: For help using the e-referral tool, go to **ereferrals.bcbsm.com** and, under *Access & Training*, click on **Training Tools**.

Here are some other articles in this issue that may be of interest

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