MARCH–APRIL 2024

BCN Provider News

Don't submit referrals for members with BCN point-of-service plans

POS health plan referrals cannot be submitted via e-referral

Blue Care Network POS health plans don't require referrals. Beginning April 1, 2024, the e-referral system will reject all 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 will reject all 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**.

Feedback | Subscribe

Inside this issue…

Updated information about non-emergency ground ambulance providers and data for discharge planning

Our network of ground ambulance providers has expanded. In addition, we compiled ground ambulance data to support our facility partners with discharge planning.

Keep reading to learn more.

Our ground ambulance provider network expanded in June

Starting June 1, 2023, Medstar joined Blue Cross Blue Shield of Michigan and Blue Care Network's network of nearly 200 ground ambulance service providers. Medstar is now a contracted, or participating, provider.

As a reminder, you must order transfers from **contracted** ambulance services when arranging for non-emergency ground transfers. This will prevent patients from being balanced billed large amounts from noncontracted ambulance services. In some instances, members have been charged nearly four times our contracted rates.

Use our **Find a Doctor** tool on **bcbsm.com** to identify contracted providers. For step-by-step instructions on how to do this, see this **provider alert**, which was posted on May 4, 2023.

Important: Superior Ambulance Service **isn't** a contracted provider and has been balance billing members. We published provider alerts about this in **October 2022** and **May 2023**.

Note: Medstar provides services in Bay, Clinton, Eaton, Genesee, Ingham, Lapeer, Macomb, Oakland and Wayne counties.

Ground ambulance data for discharge planning

To support our facility partners with discharge planning for Blue Cross commercial members, we surveyed contracted ground ambulance service providers in Southeast Michigan to:

- Assess which providers make emergency runs, non-emergency runs or both
- Identify the geographic areas that are covered by each ambulance service provider

To view the survey data:

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 *Billing and Claims* on the menu bar and then click *Claims*.
6. Click the link for the document titled *Ground ambulance data for discharge planning in Southeast Michigan*.

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

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Network Operations

HEDIS medical record reviews begin in February

Each year from February through May, Blue Cross Blue Shield of Michigan and Blue Care Network conduct Healthcare Effectiveness Data and Information Set, or HEDIS®, medical record reviews for members who live in Michigan. This year, Blue Cross' HEDIS clinical consultants will conduct these reviews for services rendered in 2023 for members with:

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

In support of HEDIS and other government programs, the Blue Cross and Blue Shield Association mandates which entities can retrieve medical records for patients living in Michigan but enrolled in another state's Blue plan. Blue Cross is authorized to retrieve medical records for patients enrolled in a Blue Medicare Advantage plan in another state.

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

For HEDIS reviews, Blue Cross looks for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results and colorectal cancer screenings. This information helps us improve health care quality reporting for our members. HEDIS reviews also require proof of service documentation for data collected from a medical record. The preferred and most efficient way to complete these reviews is through remote EMR access. For details, email Jennifer Hartman, manager, Quality and Provider Education, at **jhartman@bcbsm.com**.

You can also fax or send records through secured email. If your office works with a copy house vendor, all records be submitted timely. Your office is obligated to submit any outstanding records.

If Ciox is your copy vendor, include the following when forwarding them our record requests: **Ciox BCBSM Account Number: 2212751**.

If you have questions or concerns, email Ellen Kraft, director, Quality and Provider Education, at **ekraft@bcbsm.com**.

Network Operations

Have you subscribed to Provider Alerts Weekly?

Provider alerts offer you information you need to know between newsletters. Housed on the secure Provider Resources website, they're accessed through the payer space on our provider portal.

In response to research, last September we launched the option to subscribe to a weekly email called Provider Alerts Weekly. In it, you'll find a list of the previous week's headlines, with links so you can view the details for the alerts that interest you.

Subscriptions continue to increase as more people discover the convenience of have a week's worth of provider alerts just a click away from their inboxes on Wednesday mornings.

Go to the **Subscribe to Provider Newsletters webpage** to sign up for Provider Alerts Weekly emails.

HealthEquity to begin paying providers electronically, starting March 1

We're working with our partner, HealthEquity®, to make it easier for you to receive your payments faster.

Starting March 1, HealthEquity, the administrator of health savings accounts, or HSAs, flexible spending accounts, or FSAs, and health reimbursement arrangements, or HRAs, for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members, will begin paying our providers using VPay, an electronic payment remittance system.

If you have patients with Health Equity accounts through other health plans, you're likely already familiar with the VPay system. If this is true, there's nothing for you to do – your electronic payments will begin on March 1.

Note: If you've previously communicated with HealthEquity that you prefer to be reimbursed with paper checks, you will **not** begin receiving electronic payments.

Questions? Please call the VPay Support Center at 1-866-919-0537. For more information about the VPay system, go to **healthequity.com**.

Register now for 2024 virtual provider symposium sessions

This year's virtual provider symposiums focusing on quality measures, documentation and coding guidelines will start in May. Registration is now open on the provider training website.

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

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

Session	Date	Time
All Star Performance - HEDIS®/Star Rating Measure Overview	May 9	9 a.m. to 10 a.m.
All Star Performance - HEDIS®/Star Rating Measure Overview	May 15	9 a.m. to 10 a.m.
All Star Performance - HEDIS®/Star Rating Measure Overview	May 23	2 p.m. to 3 p.m.
All Star Performance - HEDIS®/Star Rating Measure Overview	May 30	3 p.m. to 4 p.m.

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

Session	Date	Time
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	May 7	11 a.m. to 12 p.m.
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	May 16	3 p.m. to 4 p.m.
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	May 21	9 a.m. to 10 a.m.
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	June 6	11 a.m. to 12 p.m.

Provider training website access

Provider portal users with an Availity Essentials account can access the provider training website on the *Applications* tab in the *BCBSM/BCN Payer Space*. Login through **availity.com**.

You can also directly access the training website if you do not have a provider portal account: **Provider training website**.

Questions?

For more information about the sessions, contact Ellen Kraft at **ekraft@bcbsm.com**.

For more information about registration or using the provider training website, contact the provider training team at **ProviderTraining@bcbsm.com**.

Network Operations

Webinars for physicians, coders focus on risk adjustment, coding

Beginning in April 2024, we'll offer webinars about documentation and coding of common challenging diagnoses. These live lunchtime educational sessions will also include an opportunity to ask any questions that you may have.

Below is our current schedule and the tentative topics for the sessions. All sessions start at noon Eastern time and generally last for 30 minutes. Register for the session that best works with your schedule on the provider training website.

Session date	Topic
April 17	HCC and Risk Adjustment Updates
May 22	Medical Record Documentation and MEAT
June 26	Orthopedic and Sports Medicine Coding Tips
July 10	Diabetes and Weight Management Coding Tips
August 21	Cardiovascular Disease and Vascular Surgery Coding Tips
September 18	Neurosurgery, Dementia and Cognitive Impairment Coding Tips
October 2	ICD-10-CM Updates
November 13	Oncology Coding Tips
December 11	CPT Updates 2025

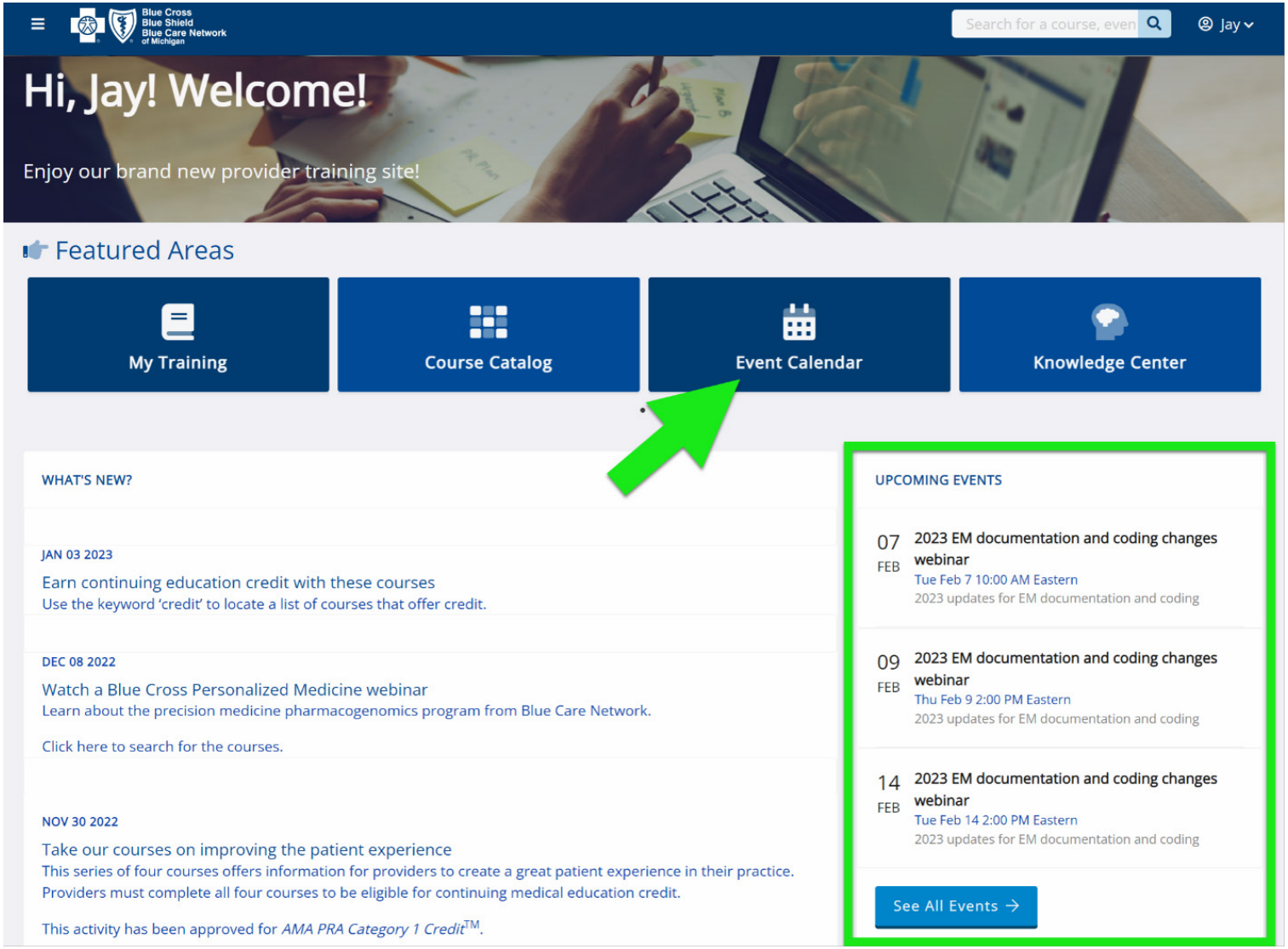
Provider training website access

Provider portal users with an Availity Essentials account can access the provider training website on the *Applications* tab in the *BCBSM/BCN Payer Space*. Login through **availity.com**.

Continued on following page

You can also directly access the training website if you do not have a provider portal account: **Provider training website**.

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



Questions?

- For more information about the sessions, contact April Boyce at **aboyce@bcbsm.com**.
- For more information about registration or using the provider training website, contact the provider training team at **ProviderTraining@bcbsm.com**.

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

Network Operations

New training course explains how to submit requests for appeals, peer-to-peer reviews in e-referral

We recently launched the *Submitting requests for appeals and peer-to-peer reviews in e-referral* course on the provider training website. This e-learning course about inpatient hospital admissions is for facility providers. The interactive course includes the simulation of an e-referral so you can quickly learn how to use e-referral's questionnaire and case communication features to submit appeal and peer-to-peer review requests. Use the keywords "facility appeals" to search the provider training website. The course is also easily found in the *Prior authorization* category of the course catalog.

To access the training site from our provider portal, follow these steps:

- Log in to the provider portal (**availity.com**).
- Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
- Under *Applications*, click on the *Provider Training Site* tile.
- Click *Submit* on the *Select an Organization* page.
- Existing users who 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, contact **ProviderTraining@bcbsm.com** to update your profile.

  Note: If you're a new training site user, 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.

You can also directly access the **provider training website** if you don't have a provider portal account.

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

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Network Operations

New mini-courses available

Action Item

Visit our provider training site to find short courses about tips for using our provider portal.

We are pleased to announce a new series of mini-courses about our provider portal through Availity. Providers interested in tips and tricks for using the portal should review the available topics. Each course only takes a few minutes to complete. We will add more topics over time based on provider feedback and interest.

Check the dashboard on our provider training site for announcements as we add more courses.

Provider training website access

Provider portal users with an Availity Essentials account can access the provider training website on the *Applications* tab in the *BCBSM/BCN Payer Space*. Login through **availity.com**.

You can also directly access the training website if you do not have a provider portal account: **Provider training website**.

Questions?

For more information about using the provider training website, contact the provider training team at **ProviderTraining@bcbsm.com**.

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

- *TruHearing network enrollment required for FEP member providers, effective Jan. 1, 2024*, **Page 32**

BCN Advantage

NaviHealth has changed its name to Home & Community Care

As of Jan. 1, 2024, naviHealth, Inc., changed its name to Home & Community Care. This is a change only to the naviHealth name.

Home & Community Care will continue to do the following for Medicare Plus Blue℠ and BCN Advantage℠ members:

- Manage prior authorizations for post-acute care services
- Provide the nonclinical, transitional care program

During first-quarter 2024:

- We'll update references to the naviHealth name in our provider portal (availity.com), on our **bcbsm.com** and **ereferrals.bcbsm.com** websites, and in our provider communications.
- The naviHealth website, **naviHealth.com**, will redirect visitors to the new website, **homeandcommunity.com**. Other naviHealth webpages will redirect to corresponding pages for a few months.
- NaviHealth email addresses will be updated, and naviHealth staff will update their email signatures.
- NaviHealth prior authorization determination letters will be updated with the new name and disclaimer. Other naviHealth letters and documents will be updated throughout the year.

For information about the prior authorization program and the nonclinical, transitional care program, see the document titled **Post-acute care: For skilled nursing, rehabilitation and long-term acute care facilities, and for nonclinical, transitional care**.

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

Continuity of care arrangements are expanded to Medicare Advantage members

Starting Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network expanded continuity of care arrangements to accommodate our Medicare Advantage (Medicare Plus Blue and BCN Advantage) members.

In the past, these arrangements applied primarily to members getting care from out-of-network providers. Now, they also apply to members who are new to our Medicare Plus Blue and BCN Advantage plans or who are moving between those plans.

Keep reading for additional information.

How continuity of care works

In line with continuity of care guidelines set by the Centers for Medicare & Medicaid Services, Blue Cross and BCN will allow members to continue with an existing course of treatment from their current provider within the first 90 calendar days after enrollment. However, first:

- Blue Cross and BCN must confirm that the member is in an active course of treatment when they join one of our Medicare Advantage plans or when they move from a Medicare Plus Blue plan to a BCN Advantage plan or vice versa.
- Providers must document the member's course of treatment or treatment plan in the member's medical record. The documentation must show the services planned for the member.
- Providers who submit a request for prior authorization should include a note that lets us know that the member is undergoing an active course of treatment.
- Blue Cross and BCN will ask for the member's treatment plan to use in reviewing the prior authorization request.

What is a course of treatment?

According to CMS, a course of treatment is a prescribed order or ordered course of treatment for a specific individual with a specific condition outlined and decided upon ahead of time with the patient and provider.

A course of treatment may be part of a treatment plan but is not required. An active course of treatment means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

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

- *Step therapy requirement to be added for Soliris and Ultomiris for Medicare Advantage members,* **Page 23**
- *Requirements and codes changed for some medical benefit drugs,* **Page 24**
- *Requirements changing for some medical benefit drugs for Medicare Advantage members,* **Page 26**
- *Billing changes for home infusion drugs for BCN Advantage members start April 1,* **Page 32**

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

Action Item

Bookmark the **Care management and utilization management programs: Overview for providers** PDF in your internet browser to make it faster and easier to access the most up-to-date information about these programs.

We publish the **overview document** to help you navigate our care management and utilization management programs. We recently updated this document and the documents linked within it to reflect changes that went into effect on Jan. 1, 2024. We'll continue to make updates as information changes.

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

- **Care management and support services**

  Care management programs provide patient support by identifying patients with health risks and working with them to improve or maintain their health, and support services provide support to members through their health journeys.

- **Utilization management**

  These programs focus on ensuring that patients get the right care at the right time in the right location through the prior authorization process.

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

In addition to accessing the document from the links above, you can also access it by clicking on the *Care and utilization management programs: Overview for providers* link at the bottom of each page of our **ereferrals.bcbsm.com** website.

Protect young children against the flu virus and receive incentive dollars in 2024

Starting January 1, 2024, providers will have the opportunity to receive an additional incentive for children receiving the flu vaccine before their second birthday. Children younger than 5 years old, and especially those younger than 2, are at high risk of developing serious flu-related complications. These complications include pneumonia, dehydration, worsening long-term medical problems, such as asthma and heart disease, encephalopathy and, in rare cases, even death. The flu vaccine provides the best protection against the flu and complications from the flu. It's recommended everyone 6 months and older receive a flu vaccine every season with rare exceptions.

Eligibility for the Childhood Immunization Status - Flu Incentive

In 2024, the Childhood Immunization Status – Flu Incentive will be available to providers participating in the Performance Recognition Program and Collaborative Quality Value-Based Reimbursement, for children turning 2 years of age from January 1 through December 31, 2024. Completion of the flu vaccine before the child's second birthday will allow providers to reach incentives for both the Combo 10 and Flu Incentive.

Continued on following page

The table below highlights all the incentive opportunities available to providers for the flu vaccine:

Measure	Physician Recognition Program (PRP)	Clinical Quality Initiative (CLQI)	Clinical Quality Value-Based Reimbursement (CQ VBR)	Blueprint for Affordability
	BCN HMO Commercial	Blue Cross Commercial PPO	Blue Cross Commercial PPO	Blue Cross Commercial PPO
Childhood Immunization Status – Combo 10*	✓	✓	✓	✓
Childhood Immunization Status – Flu	✓		✓	

*The childhood immunization status HEDIS® measure, also known as Combo 10, includes the flu vaccine and additional vaccines including DTaP, IPV, MMR, HiB, HepB, VZV, HepA and RV. Additional information on the Combo 10 measure can be found through downloading the HEDIS tip sheet through Availity®.

Special vaccination instructions for children 6 months through 8 years old

Children 6 months through 8 years old should get two doses of the flu vaccine this season if they're getting vaccinated for the first time, have previously received only one dose of flu vaccine or have an unknown flu vaccination schedule. It's recommended they get the first dose as soon as the vaccine is available as the second dose at least four weeks after the first.

Resources for health care professionals

Health care professionals, including primary care providers, nurses and pharmacists, play a significant role in protecting patients against influenza. The CDC has many resources available to help health care professionals talk to patients and their caregivers about the flu vaccine. The additional resources can be found here: **HCP Fight Flu Toolkit | CDC**.

Blue Cross also has member-facing immunization brochures available through **Availity**, which can be downloaded and shared with members.

Questions about the new flu incentive or this article can be sent to **RxQualityPrograms@bcbsm.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.

References:

1. Centers for Disease Control and Prevention. (2023, August 25). Flu vaccines are important for children. Centers for Disease Control and Prevention. https://www.cdc.gov/flu/highrisk/children.htm
2. Centers for Disease Control and Prevention. (2023a, June 29). 2023-2024 CDC flu vaccination recommendations adopted. Centers for Disease Control and Prevention. https://www.cdc.gov/flu/spotlights/2022-2023/flu-vaccination-recommendations-adopted.htm
3. Centers for Disease Control and Prevention. (2023c, October 23). HCP Fight Flu Toolkit. Centers for Disease Control and Prevention. https://www.cdc.gov/flu/professionals/vaccination/prepare-practice-tools.htm#anchor_1566404605

Medical policy updates

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.

Recent updates to the medical policies include:

Covered services

- Ambulatory event monitors and mobile cardiac outpatient telemetry
- Balloon Dilation of the Eustachian Tube (BDET)
- Charged-particle (proton or helium ion) radiotherapy for neoplastic conditions
- Computer-assisted musculoskeletal surgical navigational orthopedic procedure
- Continuous invasive glucose monitoring
- Gene expression profile analysis for risk stratification for prostate cancer management
- Germline and somatic biomarker testing (including liquid biopsy) for targeted treatment in ovarian cancer (BRCA1, BRCA2, Homologous Recombination Deficiency)
- Germline genetic testing for BRCA1, BRCA2, and PALB2 for hereditary breast/ovarian cancer syndrome and other high-risk cancers
- Interspinous/Interlaminar stabilization/distraction devices (spacers)
- Magnetic Resonance Angiography (MRA) and Magnetic Resonance Venography (MRV)
- Placental and umbilical cord blood collection and storage
- Positron Emission Tomography (PET) for oncologic conditions
- Sacroiliac joint fusion (percutaneous or minimally invasive) for the treatment of low back pain
- Somatic biomarker testing for immune checkpoint inhibitor therapy (BRAF, MSI/MMR, PD-L1, TMB)
- Transcatheter Aortic Valve Implantation (TAVI) for aortic stenosis
- Transplant-pancreas (allogeneic)

Noncovered services

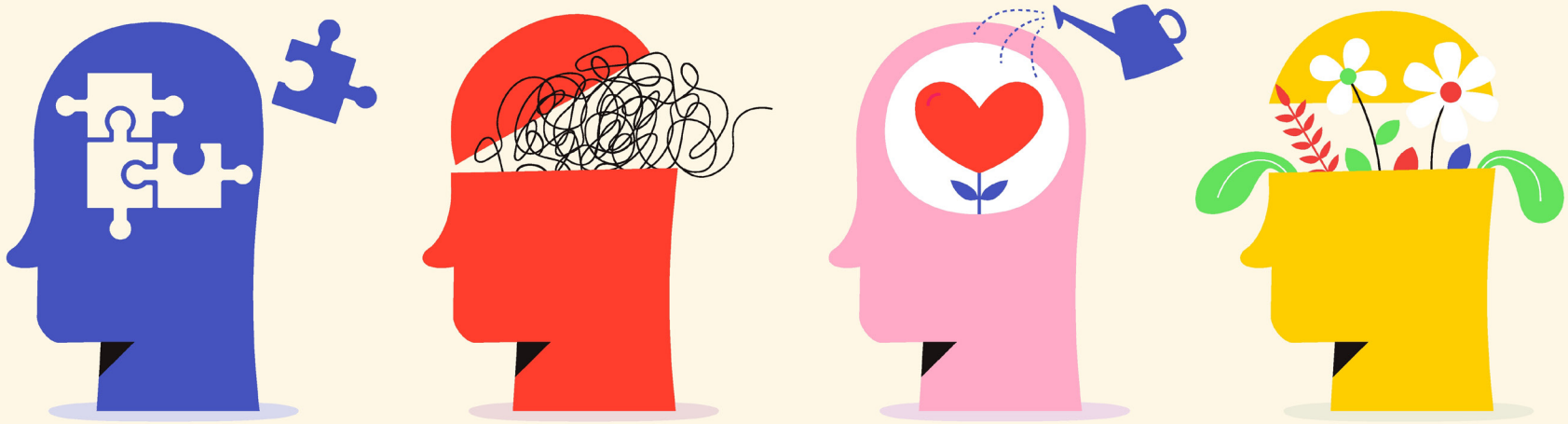
- Genetic testing-microarray testing for Cancers of Unknown Primary (CUP) origin
- Maternal serum biomarkers for prediction of adverse obstetric outcomes
- Neurofeedback
- Established services
- Magnetic Resonance Imaging for breast cancer
- Reconstructive breast surgery and management of breast implants

Mixed services

- Focal treatments for prostate cancer
- Genetic testing – preimplantation
- Germline and somatic biomarker testing (including liquid biopsy) for targeted treatment in prostate cancer (BRCA1/2, homologous recombination repair gene alterations)

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

- *Updated information about non-emergency ground ambulance providers and data for discharge planning*, **Page 2**
- *Reminder: Document the need for a continuous glucose monitoring device in the member's medical record for continued coverage*, **Page 31**



Behavioral health providers may discuss decisions with Blue Cross Behavioral Health℠ physician reviewers

Blue Cross Behavioral Health is committed to a fair and thorough prior authorization process by working collaboratively with its participating behavioral health practitioners.

When there is a question about whether a request for authorization meets medical necessity criteria, the Blue Cross Behavioral Health utilization management clinician consults with a physician reviewer, who may either deny the request or ask the care manager to contact the practitioner for additional information.

When a physician reviewer denies a request, written notification is sent to the requesting practitioner and to the member. The notification includes the reason the request was denied as well as the phone number to call a Blue Cross Behavioral Health physician reviewer to discuss the decision, if desired. The notification also includes instructions on how to appeal the denial.

Providers have the right to discuss a decision related to medical necessity with a Blue Cross Behavioral Health medical director for behavioral health. The purpose of the peer-to-peer discussion is to exchange information about the clinical nuances of the member's medical condition and the medical necessity of the treatment services, not to talk about the criteria.

For decisions on inpatient admissions, Blue Cross Behavioral Health allows onsite physician advisors at contracted facilities to discuss reviews of inpatient admissions with a Blue Cross Behavioral Health medical director. In accordance with Blue Cross and Blue Care Network policy, facilities should initiate peer-to-peer conversations only through their employed physician advisors and not through third-party advisors or organizations.

For information about how to contact Blue Cross Behavioral Health to discuss a behavioral health determination, refer to the document **How to request a peer-to-peer review with a Blue Cross or BCN medical director**. Look under the "Behavioral health services" heading.

Billing ABA services and other ASD interventions by multiple providers on the same date of service

Blue Cross Blue Shield of Michigan and Blue Care Network have received claims for autism evaluation and treatment services in which more than one provider is billing for services that occurred at the same time for a single member.

In general, concurrent billing of services by two or more providers for a member is not eligible for reimbursement. However, this is sometimes appropriate when the member has a diagnosis of autism spectrum disorder, or ASD.

Here are some guidelines for billing for ASD services by multiple providers:

- Providers can bill concurrently for the following complementary procedure codes, with limitations on duration and frequency:
  - *97153 — applied behavior analysis
  - *97155 — protocol modification (supervision)
- Providers cannot bill concurrently for services that occur at the same time but aren't complementary. For example, don't bill for ABA treatment by a behavior technician and for services by a physical, occupational or speech therapist for the same member between 2 and 3 p.m. on the same date.

Here are some additional guidelines:

- Multiple providers can bill for services for the same member provided on the same date but at different times. For example, billing for these services is acceptable:
  - Four units of ABA services provided between 1 and 2 p.m.
  - Speech therapy services provided between 2 and 3 p.m.
  - Occupational therapy services provided between 3 and 4 p.m.

- The medical necessity of each service must be clearly documented in the member's medical record. The record must show the interaction among the services and the beneficial effects for the member.

We encourage providers to use their best clinical judgment. Autism-related interventions are difficult and tiring for the member. Take into consideration the fatigue factor, the attention span and the age of the member and the member's ability to benefit from a specific intervention in light of emotional distress and frustration. For example, it may be hard to justify a speech therapy intervention when the member has already had eight hours of ABA that day. In that situation, the member may not benefit from the speech therapy due to fatigue.

Providers should consider all these factors when determining the medical necessity of the interventions. The medical record must show that the member can benefit from each intervention — rather than simply being present for the session.

Pharmacy News

Update: Additional medical oncology drugs to have requirements for most members

As part of the Oncology value management program, we're adding a prior authorization requirement or a site-of-care requirement for the drugs shown below:

Drug name	New requirement / effective date	Members
Generic paclitaxel protein-bound particles, HCPCS code J9258	Prior authorization requirement applies to dates of service on or after Jan. 1, 2024.	• Blue Cross commercial • BCN commercial • Medicare Plus Blue • BCN Advantage
Pemrydi RTU® (pemetrexed injection), HCPCS code J9324		
Columvi™ (glofitamab-gxbm), HCPCS code J9286	Prior authorization requirement applies to dates of service on or after March 1, 2024.	
Epkinly™ (epcoritamab-bysp), HCPCS code J9321		
Imjudo® (tremelimumab-actl), HCPCS code J9347	Site-of-care requirement applies to dates of service on or after March 1, 2024. (Prior authorization is already required.)	BCN commercial
Zynyz™ (retifanlimab-dlwr), HCPCS code J9345		

Continued on following page

The Oncology value management program is administered by Carelon Medical Benefits Management. These drugs are part of members' medical benefits, not their pharmacy benefits.

Submit prior authorization requests to Carelon. For drugs that have a site-of-care requirement, the Carelon ProviderPortal will prompt you to select a site of care when you submit prior authorization requests. 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

How to submit prior authorization requests

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

- Through the Carelon ProviderPortal, which you can access by doing one of the following:
  - Logging in to our provider portal (**availity.com**), clicking *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space, where you'll click the *Carelon ProviderPortal* tile.
  - **Note:** If you need to request access to our provider portal, see the **Register for web tools** webpage on **bcbsm.com**.
  - Logging in directly to the Carelon ProviderPortal at **providerportal.com**.
- By calling the Carelon Contact Center at 1-844-377-1278

More information about the requirements

The above requirements apply when these drugs are administered in outpatient settings for:

- Blue Cross Blue Shield of Michigan commercial
  - All fully insured members (group and individual)
  - Members who have coverage through **self-funded groups that have opted in to the Oncology value management program**. (Although UAW Retiree Medical Benefits Trust non-Medicare plans have opted into this program, these requirements may not apply; refer to their medical oncology drug list, which is linked below.)

    Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue members
- Blue Care Network commercial members
- BCN Advantage members

Drug lists

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

- Blue Cross commercial and BCN commercial:
  - **Oncology value management program prior authorization list for Blue Cross and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- URMBT members with Blue Cross non-Medicare plans:
  - **Oncology value management program prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
  - **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare Members**
- Medicare Plus Blue and BCN Advantage members:
  - **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

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

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

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

Pharmacy News

Additional drugs to have requirements for URMBT members with Blue Cross non-Medicare plans

For dates of service on or after March 7, 2024, additional drugs will have a prior authorization requirement, a site of care requirement or both for UAW Retiree Medical Benefits Trust members with Blue Cross Blue Shield of Michigan non-Medicare plans.

See the table below for:

- Drug names and HCPCS codes
- The new requirements
- Where to submit prior authorization requests

Drug	New requirements		Submit requests through
	Prior authorization	Site of care	
Elahere™ (mirvetuximab soravtansine-gynx), HCPCS code J9063	✓		Carelon Medical Benefits Management ProviderPortal
Imjudo® (tremelimumab-actl), HCPCS code J9347	✓		
Lunsumio™ (mosunetuzumab-axgb), HCPCS code J9350	✓		
Tecvayli® (teclistamab-cqyv), HCPCS code J9380	✓		
Vegzelma® (bevacizumab-adcd), HCPCS code Q5129	✓		
Briumvi® (ublituximab-xiiy), HCPCS code J2329	✓	✓	NovoLogix® online tool
Rebyota® (fecal microbiota, livejslm), HCPCS code J1440	✓		
Skyrizi® IV (risankizumab-rzaa), HCPCS code J2327	✓	✓	

Continued on following page

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

The prior authorization requirement is applied only when the drugs are administered in an outpatient setting.

For the drugs that have a site-of-care requirement, the NovoLogix online tool will prompt you to select a site of care when you submit prior authorization requests. 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

Prior authorization and site-of-care requirements don't apply to the UAW Retiree Health Care Trust (group number 70605) or the UAW International Union (group number 71714).

How to submit prior authorization requests

To access the Carelon provider portal or the NovoLogix online tool:

1. Log in to our provider portal at **availity.com**.
2. Click on *Payer Spaces* in the menu bar and then click on the BCBSM and BCN logo.
3. On the *Applications* tab, click the tile for the Carelon ProviderPortal or the appropriate NovoLogix tool.

If you need to request access to our provider portal, see the **Register for webtools** webpage on **bcbsm.com**.

You can also log in directly to the Carelon ProviderPortal at **providerportal.com**.

More about the requirements

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

For additional information on requirements related to drugs covered under medical benefits for URMBT members with Blue Cross non-Medicare plans, see:

- **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefit Trust PPO non-Medicare Members**
- **Oncology value management program prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**

We'll update the pertinent drug lists to reflect the changes prior to the effective date.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

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.

Rystiggo to have site-of-care requirement for most commercial members starting in April

We're adding a site-of-care requirement for the drug Rystiggo® (rozanolixizumab-noli), HCPCS code J9333, which is covered members' medical benefits, for dates of service on or after April 1, 2024. The new requirement applies to most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members.

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 Rystiggo in an outpatient hospital setting.

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 Rystiggo before April 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.

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

Some Blue Cross commercial groups aren't 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 Medical Drug Prior Authorization Program for drugs administered under medical benefits. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

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 medical benefits, 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.

Find this list and other information about requesting prior authorization at **ereferrals.bcbsm.com** on the **Blue Cross Medical Benefit Drugs** page and the **BCN Medical Benefit Drugs** page.

BCN Provider *News*
Feedback

Step therapy requirement to be added for Soliris and Ultomiris for Medicare Advantage members

What you need to know

For dates of service on or after March 1, 2024, providers who request prior authorization for Soliris® or Ultomiris® for the diagnosis of myasthenia gravis will need to show that the member has first tried and failed one of these drugs:

- Vyvgart® (efgartigimod), HCPCS code J9332
- Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334

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

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

Submit prior authorization requests through the NovoLogix® online tool.

When prior authorization is required

All these drugs require prior authorization when they're administered by a health care provider in sites of care like 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
- Electronically through an 837I transaction or by using the UB-04 claim for a hospital outpatient type of bill 013X

Submit prior authorization requests through NovoLogix

To access the NovoLogix online tool:

1. Log in to our provider portal (**availity.com**).
2. Click on *Payer Spaces* in the menu bar, then click on the Blue Cross Blue Shield of Michigan and Blue Care Network logo.
3. Go to the *Applications* tab to find links to the NovoLogix tools.

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

List of requirements

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

We'll update the list 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.

Pharmacy News

Requirements and codes changed for some medical benefit drugs

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

In October, November and December of 2023, we added requirements for some medical benefit drugs. These requirements went into effect on various dates.

In addition, some drugs were assigned new HCPCS codes.

Keep reading for the details you need to know.

Changes in requirements

For Blue Cross commercial and BCN commercial members: We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name
J3590*	Casgevy™	Exagamglogene autotemcel
J3590*	Cosentyx® IV	Secukinumab
J3590*	Daxxify®	Daxibotulinum toxina-lanm
J3590*	Entyvio® SQ	Vedolizumab
J3590*	Lyfgenia™	Lovo-cel
J3590*	Omvoh™ IV and SC	Mirikizumab-mrkz
J3590*	Pombiliti™	Cipaglucosidase alfa-atga
J3590*	Rethymic®	Allogeneic processed thymus tissue–agdc
J3590*	Rivfloza™	Nedosiran - SQ injection
J3590*	Tofidence™	Tocilizumab-bavi - IV injection
J3590*	Wezlana™	Ustekinumab-auub

Continued on following page

For Medicare Plus Blue℠ and BCN Advantage℠ members: We added prior authorization requirements as follows:

HCPCS code	Brand name	Generic name	For dates of service on or after
J1745	Generic (non-biosimilar)	Infliximab	10/15/2023
J3490	Izervay™	Avacincaptad pegol	10/15/2023
J3490	Eylea® HD	Aflibercept	10/15/2023
J3590	Lantidra™	Donislecel-jujn	10/15/2023
J3590	Veopoz™	Pozelimab-bbfg	10/15/2023
J3490	Daxxify®	DaxibotulinumtoxinA-lanm	12/18/2023

Code changes

The table below shows HCPCS code changes that were effective Oct. 1, 2023 (unless otherwise noted), for the medical benefit drugs we manage.

New HCPCS code	Brand name	Generic name
C9157	Qalsody®	Tofersen
J0801	Acthar® Gel	Corticotropin
J0802	Purified Cortropin® Gel	Corticotropin
J2781	Syfovre®	Pegcetacoplan injection

Drug lists

For additional details, see the following drug lists:

- For commercial members: **Blue Cross and BCN utilization management medical drug list**
- For Medicare Advantage members: **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue PPO and BCN Advantage members**

These lists are also available on the following pages of the **ereferrals.bcbsm.com** website:

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

Additional information about these requirements

We communicated these changes previously through provider alerts. Those alerts contain additional details.

You can view the provider alerts on **ereferrals.bcbsm.com** and on our Provider Resources site, which is accessible through our provider portal (**availity.com**).

Additional information for Blue Cross commercial groups

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

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

Reminder

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

*May be assigned a unique code in the future.

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

Pharmacy News

Requirements changing for some medical benefit drugs for Medicare Advantage members

We're adding and changing requirements for some drugs covered under members' medical benefits. This applies to Medicare Plus Blue and BCN Advantage members.

Keep reading for the information you'll need.

Prior authorization to be required for two more drugs starting March 1

For dates of service on or after March 1, 2024, the following drugs will require prior authorization:

- Adzynma (ADAMTS13, recombinant-krhn), HCPCS code J3590
- Wainua™ (eplontersen), HCPCS code J3490

Submit prior authorization requests through the NovoLogix® online tool.

Step therapy requirements to change for some drugs

Providers who request prior authorization for Soliris®, Ultomiris® or Zilbrysq® for the diagnosis of myasthenia gravis will need to show that the member has first tried and failed other drugs, as follows:

Drug (s)	New requirement	Effective date
Zilbrysq (zilucoplan), HCPCS code J3490	Prior authorization	For dates of service on or after Feb. 12, 2024(1)
	Try and fail one of these drugs: • Vyvgart® (efgartigimod), HCPCS code J9332 • Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334	For dates of service on or after Feb. 12, 2024(2)
	Do both of these things, in no specific order: • Try and fail one of these drugs: - Vyvgart (efgartigimod), HCPCS code J9332 - Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334 • Try and fail Rystiggo® (rozanolixizumab-noli), HCPCS code J9333	For dates of service on or after April 1, 2024

Continued on following page

Drug (s)	New requirement	Effective date
Soliris (eculizumab), J1300 **and** Ultomiris (ravulizumab-cwvz), J1303	Try and fail one of these drugs: • Vyvgart (efgartigimod), HCPCS code J9332 • Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334	For dates of service on or after March 1, 2024(3)
	Do both of these things, in no specific order: • Try and fail one of these drugs: - Vyvgart (efgartigimod), HCPCS code J9332 - Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J9334 • Try and fail Rystiggo (rozanolixizumab-noli), HCPCS code J9333	For dates of service on or after April 1, 2024

(1) Refer to the **Nov. 13, 2023, provider alert**.

(2) Refer to the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members** published in January 2024.

(3) Refer to the **Dec. 4, 2023, provider alert**.

Soliris and Ultomiris already require prior authorization.

When prior authorization is required

These drugs will require prior authorization when they are 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

Submit prior authorization requests through the NovoLogix tool

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

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

List of requirements

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

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

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

Starting May 1, we'll require a prior authorization for some continuous glucose monitor products

Beginning May 1, 2024, providers will need to submit a prior authorization for the products listed below to continue coverage for Blue Cross and BCN commercial members. Medicare members are excluded from this change.

Affected continuous glucose monitor products	Coverage requirement*
Freestyle Libre 14 Day Reader	1. Member is insulin-requiring **OR** 2. Member has a diagnosis of diabetes and history of problematic hypoglycemia with at least one of the following: a. Recurrent (more than one) level 2 hypoglycemia events (glucose < 54 mg/dL) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan b. A history of one level 3 hypoglycemia event (glucose < 54 mg/dL) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia **OR** 3. Member has a diagnosis of diabetes and is currently pregnant while experiencing post-prandial (after mealtime) hyperglycemia
Freestyle Libre 14 Day Sensor	
Freestyle Libre 2 Reader	
Freestyle Libre 2 Sensor	
Freestyle Libre 3 Sensor	
Freestyle Libre Reader	
Dexcom G6 Receiver	
Dexcom G6 Sensor	
Dexcom G6 Transmitter	
Dexcom G7 Receiver	
Dexcom G7 Sensor	

*Coverage requirements for continuous glucose monitor products that are billed as durable medical equipment through the member's commercial medical benefit are the same as the criteria in the table above.

Please note that the coverage criteria listed in the table above apply to members who are new starts to continuous glucose monitor products effective **March 1, 2024**.

Members who use continuous glucose monitor products prior to March 1, 2024 must meet the coverage criteria listed in the table above effective **May 1, 2024**.

Action needed:

- Talk to your patients about any concerns they may have.
- Request a prior authorization electronically. If the prescription is not authorized in advance, we may not pay for it.

For more information on how to submit an authorization electronically:

- Go to **ereferrals.bcbsm.com**.
- Select *Blue Cross* for PPO members or *BCN* for HMO members.
- Click *Pharmacy Benefit Drugs* on the left.
- Request a prior authorization to show that the criteria in the table above are met.

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

Pharmacy News

Cabenuva to have requirements for most commercial members, starting May 1

For dates of service on or after May 1, 2024, we're adding prior authorization and site-of-care requirements for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Cabenuva (cabotegravir, rilpivirine), HCPCS code J0741

For members who start a new course of treatment on or after May 1, providers will need to submit a prior authorization request.

How to submit prior authorization requests

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

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

Continued on following page

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

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 Cabenuva in an outpatient hospital setting.

What about members who start a course of treatment before May 1?

- **For members who start a course of treatment with Cabenuva before May 1, 2024**, providers won't need to submit prior authorization requests for dates of service from May 1 through Nov. 1. We'll automatically approve authorizations through Nov. 1, 2024.

  These members will be able to continue receiving the drug in the original site of care during that time.
- **For dates of service on or after Nov. 2, 2024**, providers will need to submit prior authorization requests. These requests will be subject to the site-of-care requirement outlined above.

Some Blue Cross commercial groups aren't subject to these requirements

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

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

List of requirements

For a full list of requirements related to drugs covered under the medical benefit, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**. We'll update this list prior to the effective date.

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

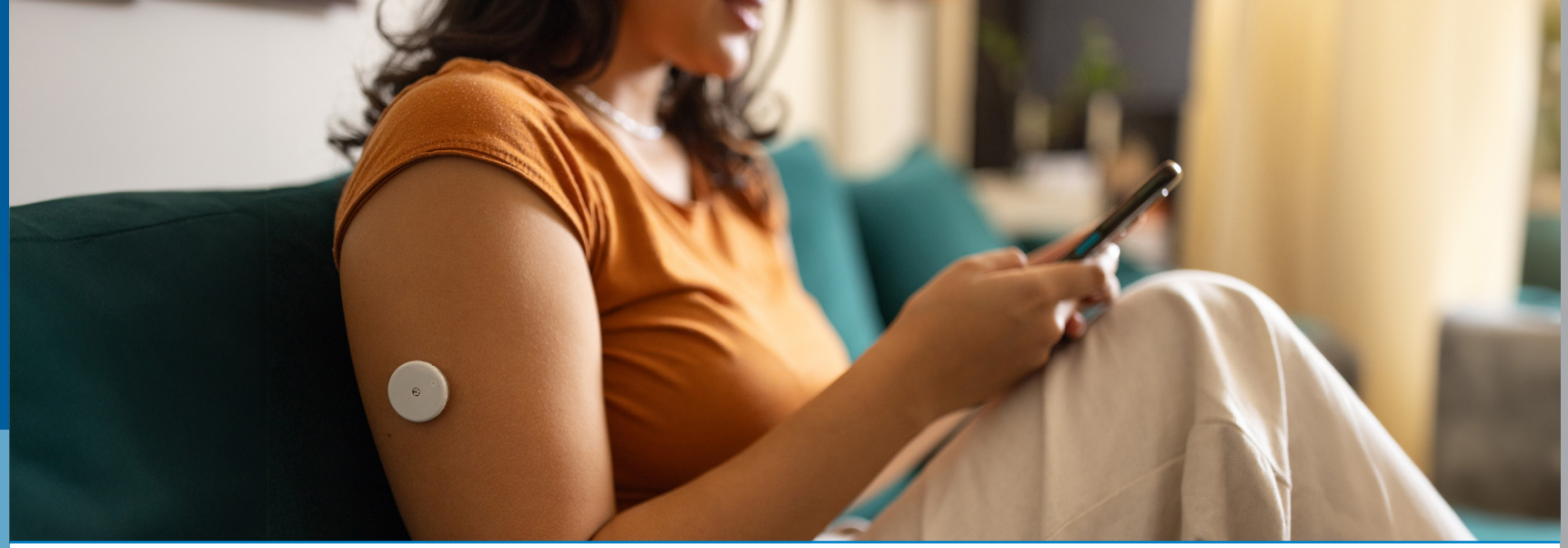
- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

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

- *Billing changes for home infusion drugs for BCN Advantage members start April 1,* **Page 32**

Billing Bulletin



Reminder: Document the need for a continuous glucose monitoring device in the member's medical record for continued coverage

As a reminder, when treating a patient with BCN commercial or BCN Advantage coverage who needs a continuous glucose monitoring device, be sure to document this need in the patient's medical record to ensure continued coverage. Without proper documentation, the patient's request for continuation of a CGM won't be approved.

The guidelines for CGM continued coverage state that every six months following the initial prescription of the CGM, the treating provider must conduct an in-person or Medicare-approved telehealth visit with the patient to document adherence to their CGM regimen and diabetes treatment plan.

Currently, some providers aren't documenting this visit. When this happens, there's no indication that the patient had a six month visit to discuss their CGM usage. As a result, their request for a CGM is being denied as not reasonable and necessary.

To ensure your patient meets the guidelines for continuation of a CGM, be sure to include the proper documentation in their medical record.

Letters to providers include the reason BCN admissions were bundled

Starting Dec. 18, 2023, the letters that Blue Care Network sends to providers to indicate that two inpatient acute medical admissions were bundled include the reason the admissions were bundled.

This change:

- Applies to admissions for BCN commercial and BCN Advantage members
- Is intended to help providers determine whether they want to appeal bundled admissions

For additional information about appealing bundled admissions, refer to the document **Guidelines for bundling admissions**.

Billing Bulletin

Billing changes for home infusion drugs for BCN Advantage members, starting April 1

Currently, BCN Advantage members have a home infusion medical benefit that covers Part D drugs administered at home. Starting April 1, 2024, these drugs will be covered under members' Part D pharmacy benefits, **not their medical benefits**.

For dates of service on or after April 1:

- Members can still have Part D medications infused at home; however, providers must bill these drugs under members' Part D pharmacy benefits.
- Providers should continue to send home infusion prescription orders to contracted home infusion providers.
- Home infusion providers must submit claims for Part D drugs to the pharmacy benefit manager and collect any applicable copays from the member.
- For drugs covered under Part B, home infusion providers should continue to submit claims to BCN Advantage.

As a reminder, providers should always check each member's eligibility and benefits through Availity® Essentials.

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.

TruHearing® is the exclusive network for FEP members, effective Jan. 1, 2024

Effective Jan. 1, 2024, TruHearing is the exclusive network for Federal Employee Program members with either BCN commercial or BCN 65 coverage. Audiologists and hearing aid providers must participate in the TruHearing network to provide services and submit claims for FEP members.

For more information on TruHearing as well as how to enroll, go to their **website** (truhearing.com) and click on the **For Providers tab**.

Billing Bulletin

BCN Provider *News*

Feedback

Clinical editing billing tips

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

This issue's tip:

- 2024 update of time for office Evaluation and Management codes

Clinical Editing Billing Tips

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

Changes to Computed tomography to detect coronary artery calcification questionnaires in the e-referral system

On Dec. 17, 2023, we updated the following questionnaires in the e-referral system for Blue Care Network commercial members:

Questionnaire	Change
Computed tomography to detect coronary artery calcification trigger	We removed this questionnaire for BCN commercial.
Computed tomography to detect coronary artery calcification	This questionnaire no longer opens for procedure code *75571.

Carelon Medical Benefits Management manages procedure code *75571 for these members. Submit all prior authorization requests — including retroactive requests — to Carelon. For more information, see the **BCN Radiology Services, High Tech** page on **ereferrals.bcbsm.com**.

Referral Roundup

Questionnaire changes in the e-referral system

On Nov. 26 and Dec. 17, 2023, we added, updated and deleted questionnaires in the e-referral system. We also added, updated and deleted the corresponding preview questionnaires from the **Authorization criteria and preview questionnaires** document 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

On Nov. 26, the following questionnaires replaced the *Dental general anesthesia or repair of trauma to natural teeth* questionnaire:

Questionnaire	Opens for	Updates
Dental general anesthesia or dental services trigger	• BCN commercial • BCN Advantage	All three questionnaires open for procedure codes *00170 and *41899
Dental general anesthesia		
Dental services		

Continued on following page

On Nov. 26, the following questionnaires replaced the *Sacral nerve neuromodulation / stimulation* questionnaire:

Questionnaire	Opens for	Updates
Urinary or fecal incontinence trigger	• Medicare Plus Blue • BCN commercial • BCN Advantage	Opens for procedure codes *64561 and *64581
Sacral nerve or gastric stimulation trigger	• Medicare Plus Blue • BCN commercial • BCN Advantage	Opens for procedure code *64590
Sacral nerve neuromodulation / stimulation for urinary incontinence	• Medicare Plus Blue • BCN commercial • BCN Advantage	Opens for procedure codes *64561, *64581 and *64590
Sacral nerve neuromodulation / stimulation for fecal incontinence	• Medicare Plus Blue • BCN commercial • BCN Advantage	Opens for procedure codes *64561, *64581 and *64590

The following questionnaires replaced the *Surgical treatment for male gynecomastia* questionnaire:

Questionnaire	Opens for	Updates
Surgical treatment for male gynecomastia	BCN commercial	Opens for procedure code *19300
BCNA surgical treatment for male gynecomastia	BCN Advantage	Opens for procedure code *19300

Updated questionnaires

On Nov. 26 and Dec. 17, we updated the following questionnaires:

Questionnaire	Opens for	Updates	Release date
Enteral nutrition	• BCN commercial • BCN Advantage	• No longer opens for procedure codes B4034, B4035, B4036, B4081, B4082, B4083, B4087, B4088 • Updated two questions • Can submit requests that span 12 months	Nov. 26, 2023
Medical formula for inborn errors of metabolism	BCN commercial	• No longer opens for BCN Advantage members • Updated a question	Dec. 17, 2023

Continued on following page

Deleted questionnaires

On Nov. 26, we deleted the following questionnaires from the e-referral system:

Questionnaire	Updates
Endovenous ablation for treatment of varicose veins	The e-referral system prompts providers to answer a series of questions instead of completing a questionnaire. For additional information, see the **Nov. 3, 2023, provider alert**.
Varicose vein treatment	
Dental general anesthesia or repair of trauma to natural teeth	These questionnaires were deleted. They were replaced with other questionnaires, as discussed in the "New questionnaires" section earlier in this article.
Sacral nerve neuromodulation / stimulation	
Surgical treatment for male gynecomastia	

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, see the document titled **Authorization criteria and preview questionnaires**.

You can access this document by going to **ereferrals.bcbsm.com** and doing the following:

- **For Medicare Plus Blue:** Click on *Blue Cross* and then click on **Prior Authorization**. Scroll down and look under the "Authorization information for Medicare Plus Blue members" heading.
- **For BCN:** Click on *BCN* and then click on **Prior Authorization & Plan Notification**. Scroll down and look under the "Authorization criteria and preview questionnaires for select services" heading.

Authorization criteria and medical policies

The *Authorization criteria and preview questionnaires* document explains how to access the pertinent authorization criteria and medical policies.

Referral Roundup

BCN Provider *News*

Feedback

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

Index

BCN Provider *News*

Feedback

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INDEX: Mar-Apr 2024

Network Operations

BCN Advantage

Patient Care/Quality

Behavioral Health

Pharmacy News

Billing Bulletin

Referral Roundup