NOVEMBER–DECEMBER 2024

BCN Provider News

Blue Cross, BCN follow nationally recognized clinical practice guidelines

Effective Dec.1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will officially follow standardized, nationally recognized and evidence-based clinical practice guidelines. These are guidelines such as those published by the United States Preventive Services Task Force and by medical professional associations, as noted in Blue Cross and BCN medical policies.

These guidelines will replace those previously published by the Michigan Quality Improvement Consortium, or MQIC, which were derived from national and local guidelines and were meant to provide concise and consistent recommendations for improving patient care.

For the past two decades, quality guidelines have been standardized at a national level. Medical societies make sure that doctors and health care providers have the best information possible when it comes to patient safety and quality. Blue Cross and BCN will use these national guidelines and information from medical societies to help us guide clinical care in our decision-making processes.

As always, you can refer to our provider portal (availity.com) for member coverage information or search for a specific medical policy on our website.

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

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Network Operations

Providers to be disenrolled after 24 consecutive months of not submitting claims

Starting Jan. 1, 2025, Blue Cross Blue Shield of Michigan and Blue Care Network will disenroll providers who haven't submitted any claims for 24 consecutive months:

- Disenrollments will occur automatically and will be carried out on a quarterly basis.
- We'll notify the providers by letter 60 days in advance.

Ending these contracts will help us keep the information in our provider directory up to date.

Why we're taking this action

Blue Cross and BCN must maintain accurate and current provider data as required by the Centers for Medicare and Medicaid Services, or CMS, the National Committee for Quality Assurance, or NCQA, and other regulatory and legislative bodies. The accuracy of provider data is essential for our members so they can make informed health care decisions and access medical services.

When providers don't submit claims, we can't be confident that they're accepting patients with Blue Cross or BCN plans. For this reason, we'll disenroll providers who don't submit claims for 24 consecutive months.

How to avoid disenrollment

For providers enrolled with both Blue Cross and BCN, submitting claims to either Blue Cross or BCN will help avoid disenrollment.

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Professional practitioners must attest to data as required in CAQH

What you need to know

To remain listed in Blue Cross Blue Shield of Michigan's provider directories, including *Find a Doctor*, professional practitioners must attest to their information in CAQH.

All professional practitioners, including those who practice at an office location or practice exclusively in an inpatient hospital setting, need to attest to their data.

Attestation must be completed in the CAQH Provider Data Portal (formerly known as CAQH ProView®) every 90 and 120 days as follows.

What to do every 90 days

Professional practitioners must attest to the following data elements every 90 days: name, specialty, address, phone number and digital contact information. Attestation is required even if no changes are needed.

This is a requirement of the Consolidated Appropriations Act.

What to do every 120 days

Professional practitioners are also required to attest to all other data elements every 120 days. This includes elements related to credentialing, licensing and elements other than those listed in the previous section.

Your credentialing status will end if you fail to attest, and you'll need to reapply.

Why you need to do this

If professional practitioners don't attest in CAQH as required, they won't be included in the Blue Cross Blue Shield of Michigan and Blue Care Network provider directories, including our *Find a Doctor* search tool.

It's important to attest with CAQH to:

- Ensure your affiliation with Blue Cross or BCN isn't interrupted.
- Keep your contact information up to date.
- Make sure claims payments aren't interrupted.

Additional information

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

CAQH is a nonprofit alliance of health plans and trade associations focused on simplifying health care administration. Blue Cross and BCN use CAQH to gather and coordinate our professional practitioner credentialing information. All health care practitioners, including hospital-based providers, must be registered with CAQH.

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

Facilities and organizational providers must use the Provider Data Management tool within Availity Essentials to update and attest to information, starting Dec. 1

In the **September-October *BCN Provider News***, we reported that facilities and organizational (or allied) providers will be able to use the Provider Data Management tool within Availity Essentials™ to update certain basic information. Facilities and organizational (or allied) providers are now able to do this.

Keep reading for information about:

- Additional changes that are coming on Dec. 1, 2024
- How to access the Provider Data Management tool within Availity
- Where to learn more about the Provider Data Management tool

What will change on Dec. 1

Starting Dec. 1, 2024, facilities and organizational (or allied) providers **will be required** to use the Provider Data Management tool within Availity Essentials to update and attest to the following information:

- Name
- Specialty
- Location
- Phone number
- Electronic contact information or website

As part of this change, we'll do the following for facilities and organizational (or allied) providers:

- Discontinue sending attestation letters through U.S. mail
- On Dec. 1, the change forms related to the above items will be removed from **bcbsm.com/providers**

For additional information — including how to access change forms to update information other than the items listed above — see the document titled **Update and attest to facility and organizational provider information in the Provider Data Management tool within Availity Essentials**.

Accessing Provider Data Management in Availity Essentials

To update and attest to provider directory data, you need the following:

1. Access to our provider portal, Availity Essentials, through your organization. If your organization isn't registered for Availity Essentials, follow the instructions on the **Register for web tools** webpage at **bcbsm.com/providers**.
2. A **user account** in Availity Essentials that has the **Provider Data Management** role. Your organization's Availity Essentials administrator is responsible for adding user accounts and assigning roles.

   Tip: To learn more about assigning roles, your Availity Essentials administrator can read the help topic *View and edit a team member's roles and permissions*. To access it, log in to Availity Essentials, click *Help & Training* and then click *Find Help*. Enter the name of the help topic in the *Search* field, press *Enter* and then click the link for the help topic.

Where to learn more about Provider Data Management

Availity Essentials has training on provider data management and directory verification. To access the training:

1. Log in to our provider portal (**availity.com**).
2. Click *Help & Training* at the top of the screen and then click *Get Trained*.
3. Enter *Provider Data Management* in the *Search* field to search the catalog.
4. Click the link for the BCBSM-specific provider data management course to register.

If you have trouble accessing training or while working in Availity Essentials, call Availity Client Services at 1-800-AVAILITY (282-4548).

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

Blue Care Network is making minor changes to group and individual health plans in 2025

Starting on Jan. 1, 2025, Blue Care Network will be modifying some of the health plans we offer to both groups and individuals. Here's a quick summary of what's changing.

Group health plans

- Out-of-pocket maximums will be decreasing slightly for non-Health Savings Account plans – from $9,450 single/$18,900 family in 2024 to $9,200 single/$18,400 family in 2025.
- We're offering a new health reimbursement arrangement:
  - *Blue Elect Plus POS HRA*

    Allows employer groups to pair a health reimbursement account with any of our *Blue Elect Plus POS* options.
- We're discontinuing two plans:
  - *BCN Virtual Primary Care*
  - *Healthy Blue Living℠ Basic*

    Note: *Healthy Blue Living℠* is available for 2025 – only *Healthy Blue Living℠ Basic* is being discontinued.

Individual health plans

- Out-of-pocket maximums will be reduced from $9,450 individual/$18,900 family in 2024 to $9,200 individual/$18,400 family in 2025
- The pediatric dental out-of-pocket maximum will be increased from $400 in 2024 to $425 in 2025
- We're decreasing the number of BCN health plans available for purchase by individuals from 33 in 2024 to 28 plans in 2025
- We're discontinuing five plans:
  - *Blue Cross Preferred HMO Virtual Primary Care Silver*
  - *Blue Cross Preferred HMO Virtual Primary Care Bronze*
  - *Blue Cross Preferred HMO Bronze*
  - *Blue Cross Metro Detroit HMO Bronze*
  - *Blue Cross Select HMO Bronze*

Check eligibility and benefits

Remember to check member eligibility and benefits at each visit to see that the coverage is in effect and review the member's coverage for the services you provide. You can check eligibility and benefits through:

- Our provider portal, using the Eligibility and Benefits Inquiry application
- Provider Inquiry, with automated response available 24 hours a day, and representatives available 8 a.m. to 5 p.m., Monday through Friday
  - Professional providers call 1-800-344-8525
  - Hospital and facilities call 1-800-249-5103
  - Vision and hearing providers call 1-800-482-4047
- HIPAA 270/271 electronic standard transaction

Webinars for physicians, coders focus on risk adjustment, coding

We're offering webinars to explain documentation and coding of common challenging diagnoses. These live, lunchtime educational sessions will also include an opportunity to ask questions.

Below is our 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
Nov. 13	Oncology Coding Tips
Dec. 11	CPT Updates 2025

Provider training website access

Provider portal users with an Availity Essentials™ account can access the provider training website by logging in to **availity.com**, clicking on *Payer Space* in the top menu bar and then clicking on the BCBSM and BCN logo. Then click on the *Applications* tab, scroll down to the *Provider Training Site* tile and click on it.

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

After logging in to the provider training website, look in *Event Calendar* to sign up for your desired session. You can also quickly search for all the sessions with the keyword "lunchtime" and then look under the results for *Events*.

You can listen to the previously recorded sessions too. Check out the following:

Previously recorded	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
Aug 21	Cardiovascular Disease and Vascular Surgery Coding Tips
Sept 18	Neurosurgery, Dementia, Cognitive Impairment Coding Tips
Oct. 2	ICD-10-CM Updates

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**.
- For more information on accessing the provider training website through the provider portal see the **"Access our training site from our provider portal; new learning path available"** article in the December *2023 Record*.

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.

On-demand opportunities available for training

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

The following learning opportunities are available:

- Prior Authorization Programs with Carelon presentation

  This recorded webinar builds on the webinar held earlier this year to deep dive into some intermediate topics such as denials and appeals. Search for this session on the provider training site with the keyword "Carelon."

  If you have not already done so, we recommend completing these additional courses about working with Carelon:

  - Carelon Medical Benefits Management overview e-learning

    This 15-minute module reviews of the basics on working with Carelon Medical Benefits Management.

  - Prior Authorization Program with Carelon Medical Benefits Management presentation

    This webinar was recorded in June of 2024. It has an overview of the processes and a step-by-step demonstration of submitting a prior authorization request in the Carelon provider portal.

- Medicare Advantage Post-Acute Care Prior Authorization Program

  Learn about the changes related to post-acute care services for Medicare Advantage members. This recorded presentation discusses the process changes and what providers need to do as of October 1, 2024. Search for this session on the provider training site with the keyword "post-acute."

Continued on following page

Network Operations

How to access provider training

To access the training site, follow these steps:

1. Log in to the provider portal at **availity.com**.
2. Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
3. Under *Applications*, click on the *Provider Training Site* tile.
4. Click on *Submit* on the *Select an Organization* page.
5. 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.

Those who don't have a provider portal account can directly access the training through the **Provider training website**.

Questions?

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

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.

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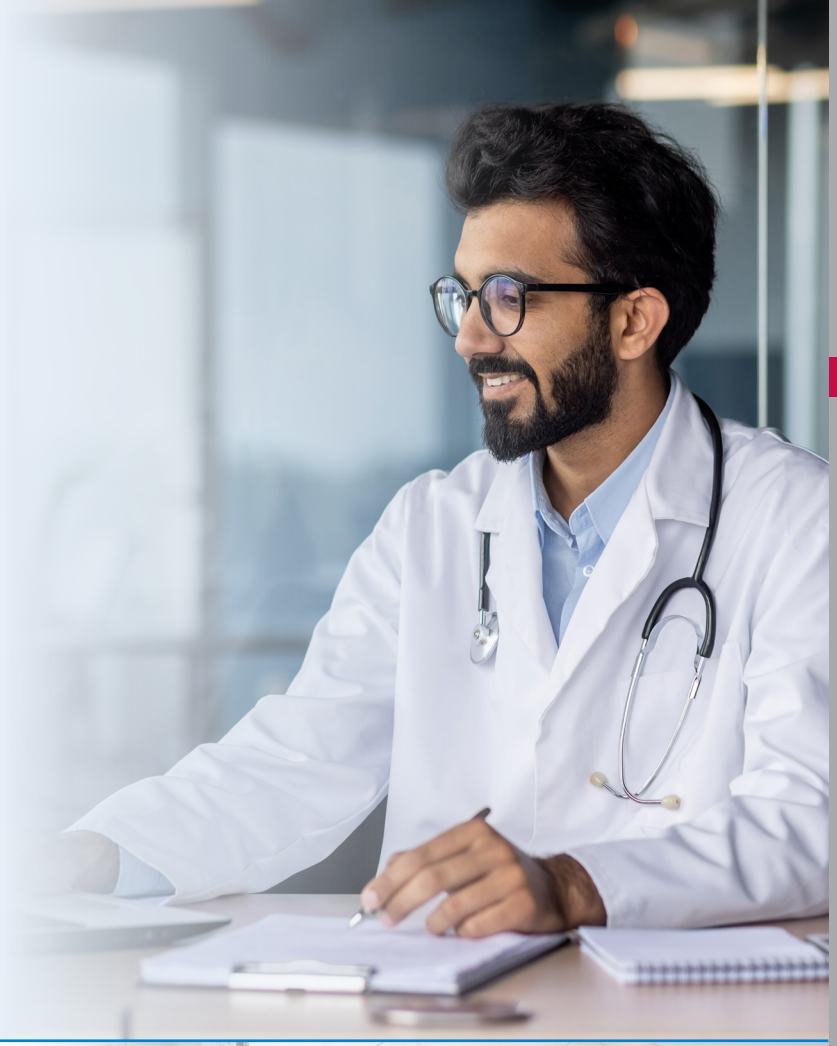
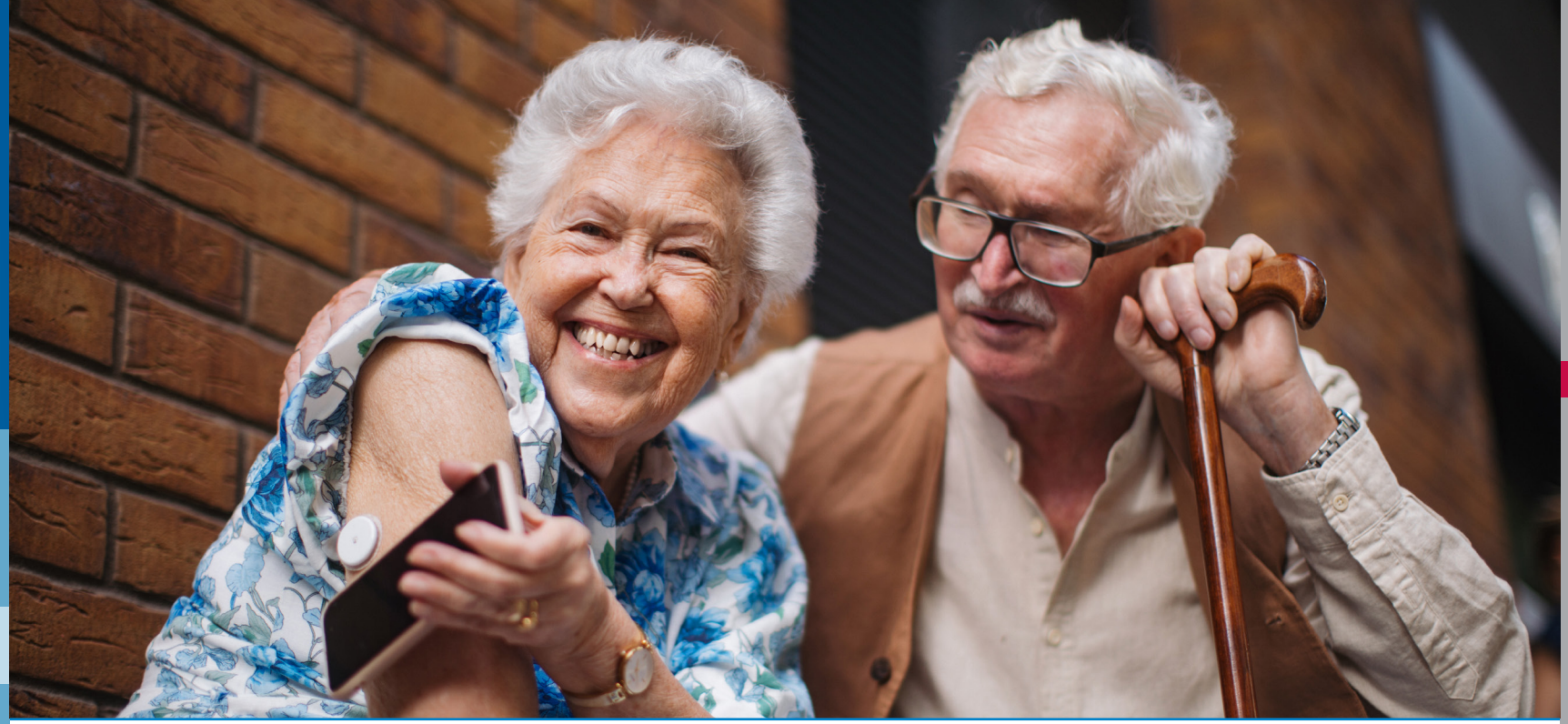


Here are some other articles in this issue that may be of interest

- *Close the gap in Statin Use in Persons with Diabetes measure*, **Page 13**
- *New Behavioral Health course added to learning path*, **Page 16**

BCN Advantage



Medicare Advantage members must obtain continuous glucose monitor products through a pharmacy, starting Oct. 1

For dates of service on or after Oct. 1, 2024, Medicare Plus Blue and BCN Advantage members must obtain their continuous glucose monitor products through a participating network pharmacy.

Blue Cross Blue Shield of Michigan and Blue Care Network no longer cover CGM products dispensed by contracted and noncontracted durable medical equipment, or DME, suppliers for Medicare Advantage members.

Exception: UAW Retiree Medical Benefits Trust members are excluded from this change. These members should continue to purchase their CGM products through a DME supplier.

What changed

When this change went into effect on Oct. 1:

- Medicare Plus Blue and BCN Advantage members who receive their CGM products through a DME supplier require a new prescription to be filled at a pharmacy.
- Participating pharmacies are able to dispense CGM products through members' Part B benefits at point of sale: FreeStyle Libre and Dexcom are the preferred brands. The CGM products are billed under the members' medical benefits, not their pharmacy benefits.

Note: Coverage criteria still applies.

Additional information

We notified affected members of these changes and encouraged them to talk with their provider about getting a new prescription prior to Oct. 1, if needed, and to discuss any concerns.

Our provider manuals and related documents have been updated to reflect this change.

Preferred immune globulin products for Medicare Advantage members to change, starting Nov. 1

For dates of service on or after Nov. 1, 2024, preferred and nonpreferred immune globulin products are changing for Medicare Plus Blue and BCN Advantage members.

Providers will have to show that our Medicare Advantage members have tried the preferred immune globulin products before requesting prior authorization for the nonpreferred products. See the table below:

Preferred products	Nonpreferred products
Try and fail: Gammagard®, HCPCS code J1569 **and** Octagam®, HCPCS code J1568	Privigen®, HCPCS code J1459
	Asceniv®, HCPCS code J1554
	Bivigam®, HCPCS code J1556
	Gammaplex®, HCPCS code J1557
	Gamunex-C®, Gammaked™, HCPCS code J1561
	Gammagard S/D® Less IgA, HCPCS code J1566
	Flebogamma® DIF, HCPCS code J1572
	Panzyga®, HCPCS code J1576
	Alyglo™, HCPCS code J1599
Try and fail: Gammagard, HCPCS code J1569 **or** Octagam, HCPCS code J1568, and Hizentra®, HCPCS code J1559	Cutaquig®, HCPCS code J1551
	Cuvitru®, HCPCS code J1555
	Xembify®, HCPCS code J1558
	Hyqvia®, HCPCS code J1575

Note: Use of Gammagard or Octagam is required prior to starting Hizentra but will not be required for the diagnosis of chronic inflammatory demyelinating polyneuritis (CIDP).

Submit prior authorization requests through the NovoLogix® online tool when these drugs will be billed as a medical benefit.

When prior authorization is required

These medications require prior authorization when 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

How to access NovoLogix

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

Note: If you need to request access to our provider portal, follow the instructions on the **Register for 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 this list prior to the effective date.

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BCN Advantage

Upcoming 2025 Medicare Advantage, Part D formulary changes may require prescribing alternative drugs

Changes to Blue Cross Blue Shield of Michigan and Blue Care Network's 2025 drug formularies may require providers to prescribe alternative medications to some of our Medicare Plus Blue℠, BCN Advantage℠ or Prescription Blue℠ PDP plan members starting January 1, 2025.

To comply with federal government constraints and Part D redesign provisions expected in 2025, we're adjusting our formulary and utilization management requirements. We collaborated with physicians and pharmacists to develop a comprehensive formulary strategy considering several factors like safety, efficacy and cost.

As a result, some of the drugs currently on our formularies will be:

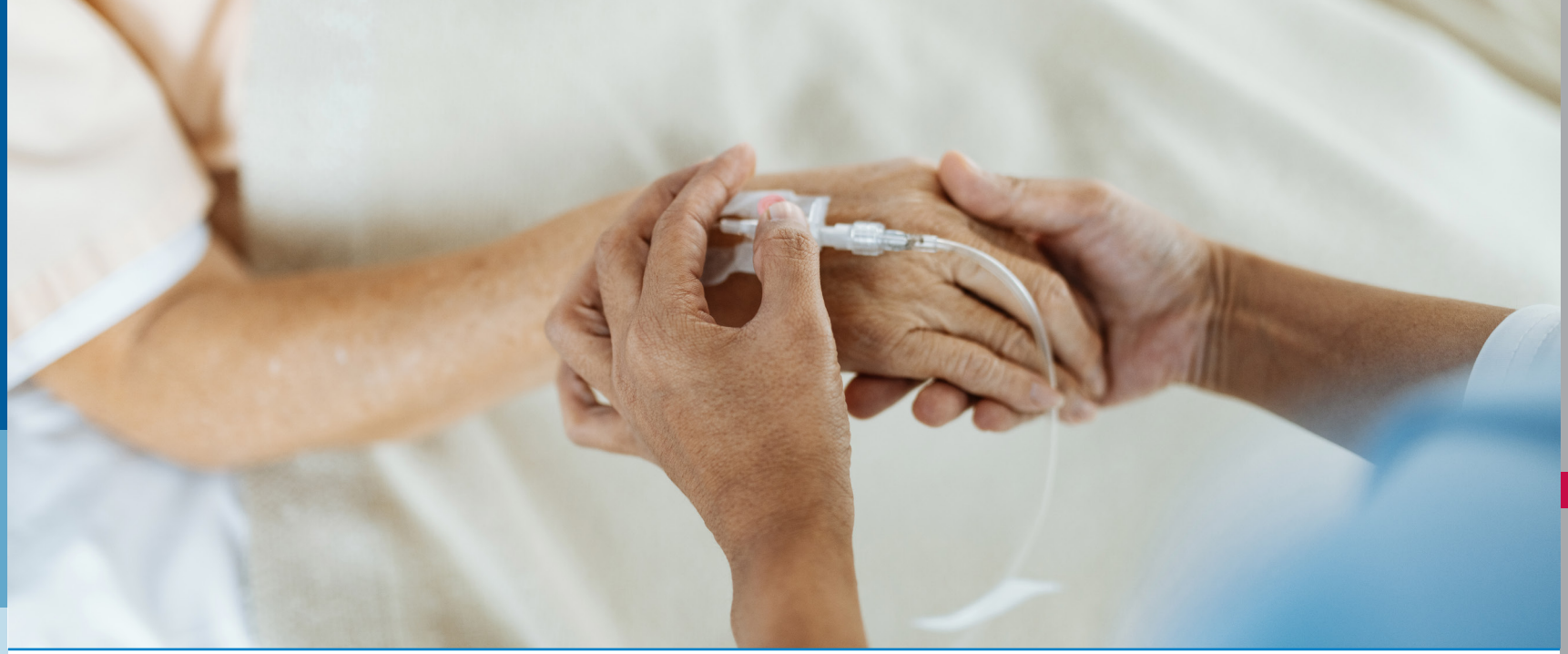
- Removed from our formularies
- Moved to higher tiers
- Added to the list of drugs requiring prior authorization, step therapy or quantity limits

Because the upcoming formulary modifications are more significant compared to previous years, we anticipate that physicians may observe an increase in patient calls and may need to prescribe alternative medications. Nevertheless, the majority of current medications have suitable replacements that we'll continue to cover. Our projections indicate that approximately two-thirds of our members will not experience an increase in out-of-pocket costs.

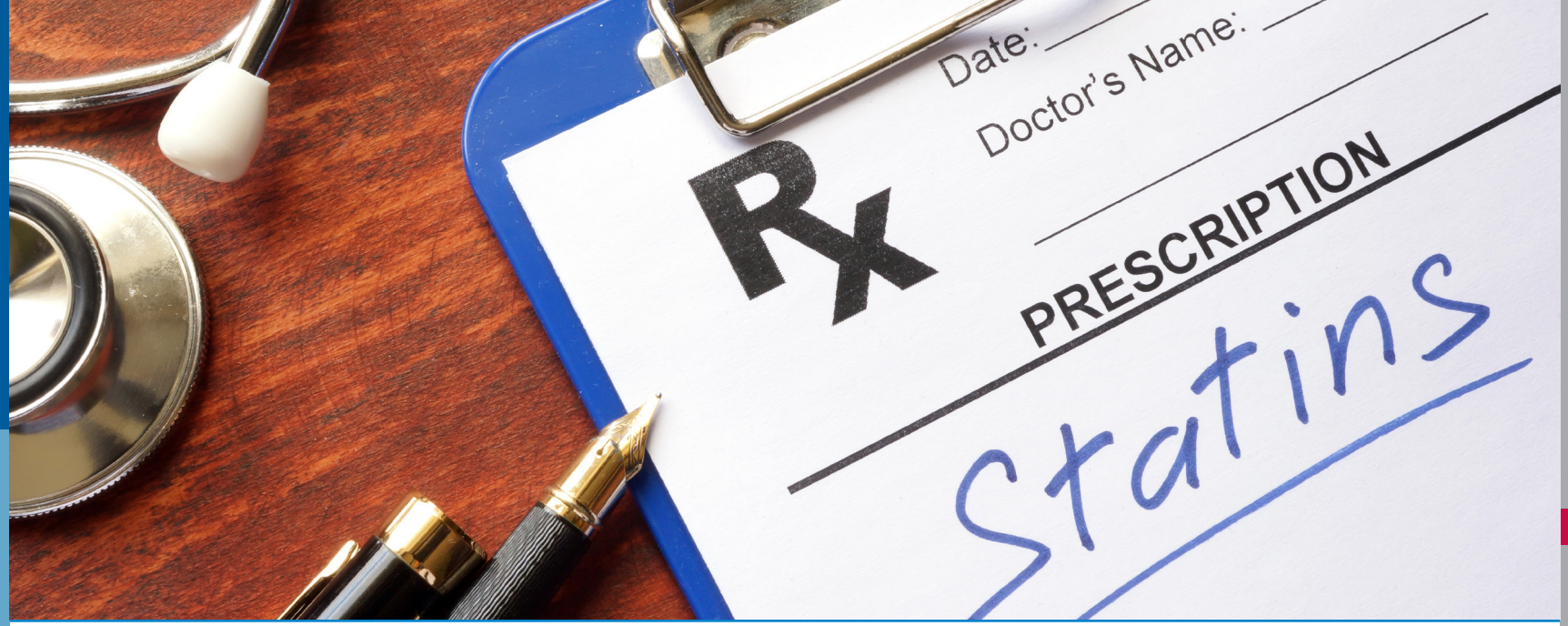
To ensure a smooth transition, we recently mailed letters to specific providers detailing these changes. These letters include a list of their patients who may experience disruptions in their current formularies, along with suggestions for suitable alternative prescriptions, so providers can prepare in advance.

The 2025 formularies have been posted on our website. We're also educating pharmacists about potential changes that can be directly managed at pharmacy level.

BCN Advantage



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



Close gaps in Statin Use in Persons with Diabetes measure

The Centers for Medicare & Medicaid Services defines the Statin Use in Persons with Diabetes, or SUPD, Medicare Star measure as the percent of Medicare Part D patients between 40 and 75 years old who received at least two diabetes medication fills, and who also received a statin medication fill during the calendar year. Guidelines from the American Diabetes Association, American College of Cardiology and the American Heart Association support the use of statins in patients with diabetes for cardiovascular risk reduction, regardless of LDL cholesterol levels.

How to close a gap in the SUPD measure

The patient must have a paid claim for a statin through the Part D benefit, or the health care provider must bill an eligible ICD-10 diagnosis code to remove the patient from the measure if a statin isn't appropriate. A claim or code must occur every year the patient is in the measure for the gap to be closed. Additionally, only certain diagnosis codes will close a gap, such as those for myopathy, myositis, pre-diabetes and abnormal blood glucose, for example. A list of eligible ICD-10 codes can be found on this **tip sheet**.

If the patient doesn't have an upcoming appointment in the calendar year, providers may also call the patient to confirm the ICD-10 diagnosis code, document it in the medical record and then bill the non-reimbursable HCPCS code G9781 for $0.01 with the applicable ICD-10 code attached to process the claim and remove the patient from the Star measure.

Note: Only statin claims billed through the patient's Part D plan count toward closing gaps in the measure.

The following types of statin claims will not close a gap in the SUPD measure:

- Claims filled through Good Rx or pharmacy discount programs (for example, Kroger Health Savings Club, Amazon RxPass)
- Cash claims
- Medication samples
- Fills from Veterans Affairs facilities
- Fills billed to a non-Medicare insurance plan

Our program to help reduce avoidable inpatient readmissions for Medicare Advantage has changed

We're offering a new program through Blue Cross Coordinated Care℠ Core to reduce avoidable inpatient admissions for Medicare Plus Blue℠ and BCN Advantage℠ members.

On Sept. 30, 2024, the nonclinical, transitional care program through Home & Community Care (formerly known as naviHealth, Inc.) for members who are discharged from acute inpatient facilities to certain post-acute care facilities in Michigan ended. Home & Community Care navigation specialists provided support to all members who engaged with the program before the end date.

Starting Oct. 1, 2024, care managers from Blue Cross Coordinated Care work with members who are eligible for the Blue Cross Coordinated Care program and are at risk for unsuccessful discharge to their homes from acute inpatient facilities or from post-acute care facilities.

For more information about Blue Cross Coordinated Care, see the document titled **Blue Cross Coordinated Care Core: For members with complex, chronic and acute conditions**.

Home & Community Care is an independent company that provided nonclinical, transitional care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Quality MINUTE

Blue Cross Blue Shield Blue Care Network of Michigan

An ongoing series of quick tips designed to be read in 60 seconds or less and provide your practice with information about performance in key areas.

Plan All Cause Readmissions

- Connect with the Michigan Health Information Network (MiHIN) to receive automated electronic admission, discharge and transfer (ADT) notifications for your patients.
- Upon notification of a discharge, outreach to patients if they do not initiate contact within 7 days. The 7-day post-discharge window is critical period to prevent readmissions.
- Complete medication reconciliation post-discharge to prevent medication-related hospital readmissions. When medication reconciliation post-discharge is completed, submit CPT II code, 1111F on a claim. 1111F is payable for Medicare Plus Blue and BCN Advantage members with no member cost share.
- Use member eligibility files to ensure a patient-provider relationship is established for all assigned/attributed members. This is especially important for Blue Care Network and BCN Advantage members who may be assigned to providers without an established relationship with the provider.

Medical policy updates

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

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

Recent updates to the medical policies include:

Covered services

- Air ambulance services for non-emergent transports
- Autografts and allografts in the treatment of focal articular cartilage lesions
- BMT – Hematopoietic Cell Transplantation for germ-cell tumors
- BMT – Hematopoietic Cell Transplantation for non-Hodgkin lymphomas
- BMT – Hematopoietic Cell Transplantation for solid tumors of childhood
- Genetic testing for marfan, ehlers-danlos, thoracic aortic aneurysms and dissections, and connective tissue related disorders
- Inhaled Nitric Oxide (iNO)
- Leadless cardiac pacemakers
- Myoelectric prosthetic and orthotic components for the upper limb
- Pneumatic compression pumps and appliances (e.g., Flexitouch™ Systems) for lymphedema
- Pneumatic compression pumps and appliances for venous ulcers
- Skin and tissue substitutes
- Transplant – islet cell (autologous) for chronic pancreatitis
- Transplant – liver
- Transplant – lung and lobar lung

Noncovered services

- Annular closure devices (e.g., Barricaid®, Xclose®, Inclose™)
- Fetal magnetocardiography (fMCG)
- Radiofrequency Ablation of peripheral nerves to treat pain including Coolief Cooled RF

Established services

- Contraception and voluntary sterilization
- Elemental formula
- Reconstructive breast surgery and management of breast implants
- Surgical treatment of femoroacetabular impingement
- Telemedicine services

Experimental/Investigational services

- Digital health technologies: diagnostic applications (behavioral health disorders including Autism Spectrum Disorder)
- Molecular testing in the management of pulmonary nodules

Mixed services

- Facet joint denervation

Medical Policy Updates

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

- *Blue Cross and BCN follow nationally recognized clinical practice guidelines,* **Page 1**
- *Upcoming closures of Rite Aid, Walgreens retail pharmacies,* **Page 20**
- *Blue Cross, BCN cover additional RSV vaccine,* **Page 24**
- *Quality Minute – Hierarchical Condition Category (HCC) Coding Persistency,* **Page 30**

New behavioral health course added to learning path

Action item

Visit our provider training site to find short and new courses about working with our processes.

The behavioral health learning path features a new course, "Behavioral Health Basics." The course is designed to close knowledge gaps in several areas of behavioral health to give a well-rounded view of behavioral health at Blue Cross Blue Shield of Michigan and Blue Care Network.

The course addresses potential provider challenges, reviews current resources, walks through scenarios and challenges the learner's knowledge along the way. From the introduction module through eight other modules, it starts with enrollment and ends at resources. You can also find new courses in the learning path, such as mini modules on the Behavioral Health portal.

Professional providers and facilities should encourage those in the behavioral health field to view the course, as well as the other courses in the learning path. Simply open the Course Catalog on the **Provider training website**, and click on *Learning paths*.

We also added the following learning opportunity:

- **InterQual criteria in e-referral**

  This mini module shows you step by step how to launch and complete the InterQual criteria. Use this module as a quick start guide for the new feature in e-referral.

How to access provider training

To access the training site, follow these steps:

1. Log in to the provider portal at **availity.com**.
2. Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
3. Under *Applications*, click on the *Provider Training Site* tile.
4. Click on *Submit* on the *Select an Organization* page.
5. 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.

Those who don't have a provider portal account can directly access the training through the **Provider training website**.

Questions?

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

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

- *Blue Cross and BCN follow nationally recognized clinical practice guidelines,* **Page 1**
- *Follow these guidelines for billing split or shared visits,* **Page 28**

Pharmacy News

Update on the Oncology Value Management program through OncoHealth

OncoHealth® will manage prior authorizations for medical benefit oncology and supportive care drugs for most members through the Oncology Value Management program. This applies to dates of service on or after Jan. 1, 2025.

Here's a correction to information we reported about this in the September-October *BCN Provider News*: Starting Jan. 1, 2025, OncoHealth will manage medical benefit oncology drugs. Pharmacy benefit oncology drugs will continue to be managed by Blue Cross Blue Shield of Michigan or Blue Care Network until March 31, 2025; OncoHealth will begin managing pharmacy benefit oncology drugs on April 1, 2025.

Here's some additional information about this change.

Enhanced reimbursement is ending

Starting Jan. 1, 2025, the Oncology Value Management program will no longer offer providers enhanced reimbursement for medical oncology services billed with HCPCS codes S0353 and S0354.

Note: The enhanced reimbursement will continue to be available for Blue Cross Blue Shield of Michigan UAW Retiree Medical Benefits Trust non-Medicare members because Carelon will continue to manage prior authorizations for medical benefit oncology drugs for these members.

How to submit retroactive authorization requests starting Jan. 1

Starting Jan. 1, 2025, submit retroactive authorization requests with dates of service on or before Dec. 31, 2024, to OncoHealth.

Register for a live webinar

To register for a webinar, see the following article in this issue: *Register for a live webinar about the Oncology Value Management program through OncoHealth*.

Watch for additional provider alerts and newsletter articles about this change.

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.

OncoHealth is an independent company supporting Blue Cross Blue Shield of Michigan and Blue Care Network by providing cancer support services.

Register for a live webinar about the Oncology Value Management program through OncoHealth

On Jan. 1, 2025, OncoHealth® will manage prior authorizations for medical benefit oncology and supportive care drugs for most members through the Oncology Value Management program.

Health care providers who submit prior authorization requests for oncology drugs covered under the medical benefit should attend a live webinar to learn more about the changes that are coming Jan. 1.

The webinars will:

- Provide an overview of the services that will require prior authorization by OncoHealth
- Explain how to submit prior authorization requests, including the supporting documentation to include with requests
- Provide a demonstration of OncoHealth's prior authorization portal
- Review the prior authorization workflow

There will be time for a question-and-answer session at the end of each webinar.

Click one of the links below to register.

Date	Time	Registration link
Thursday, Nov. 21, 2024	2 to 3 p.m.	Click here to register
Tuesday, Dec. 3, 2024	11 a.m. to noon	Click here to register
Thursday, Dec. 12, 2024	2 to 3 p.m.	Click here to register
Tuesday, Dec. 17, 2024	11 a.m. to noon	Click here to register
Tuesday, Jan. 7, 2025	11 a.m. to noon	Click here to register
Thursday, Jan. 9, 2025	2 to 3 p.m.	Click here to register

See the Update on the *Oncology Value Management program through OncoHealth* article in this issue for additional information about the Jan. 1 changes for the Oncology Value Management program.

Watch for additional provider alerts and newsletter articles about this change.

Pharmacy News

Medicare Prescription Payment Plan available to help Medicare members manage drug expenses

Starting in 2025, your patients with any of our Medicare Advantage plans with Part D coverage or Prescription Blue℠ PDP will have the option to participate in the Medicare Prescription Payment Plan, or M3P, to help manage their out-of-pocket Medicare Part D drug costs.

The new payment option stems from the prescription drug law, established by the Inflation Reduction Act, which requires all Medicare prescription drug plans, either standalone or MA plans that include Part D coverage, to offer enrollees the option to spread their prescription costs throughout the calendar year. Members who select this payment option will continue to pay their plan premium each month, if they have one, but will get a bill from Blue Cross Blue Shield of Michigan or Blue Care Network to pay for their prescription drugs instead of paying the pharmacy. Members who have high drug costs are most likely to benefit from this plan.

We anticipate your patients may ask you about this payment option.

What you need to know

Members will receive the M3P election participation request form with their annual enrollment materials. Participation is voluntary and members won't pay any interest or fees on the amount owed, even if a payment is late. To participate, they have several options. Members can:

- Opt-in online
- Contact Blue Cross Blue Shield of Michigan or Blue Care Network by phone
- Send a completed form to Blue Cross or BCN by mail

M3P won't lower their drug costs but might help them manage their monthly expenses.

The member's payments might change every month, so they might not know what their exact bill will be ahead of time. Their monthly bill is based on what they would have paid for any prescriptions they get, plus their previous month's balance, divided by the number of months left in the year. Their future payments may increase as they continue to fill prescriptions throughout the rest of the year.

Who may not benefit from M3P

The program isn't optimal for all Medicare Part D beneficiaries. Members who may not benefit from it include those who:

- Have low yearly drug costs
- Have the same drug costs each month
- Receive Extra Help from Medicare or other help paying for their Part D prescription drugs
- Are in employer group plans with set copay amounts

For more information, your patients can contact us or visit www.Medicare.gov to determine if this option is right for them.

Upcoming closures of Rite Aid, Walgreens retail pharmacies

Rite Aid is closing hundreds of stores throughout the Midwest, and Walgreens announced plans to close some of its stores over the next three years. Thousands of affected members may need assistance finding a new pharmacy that's in network with their Blue Cross Blue Shield of Michigan or Blue Care Network health plan.

Q. How can members find a new pharmacy?

A. For the information about their plan and benefits, members should log in to their **member account**, use the Blue Cross **mobile app** or call the number on the back of their member ID card.

The resources below are also available for members who need more assistance.

Blue Cross and BCN commercial members

- Visit the **Find a Pharmacy webpage**.
- Check out the list of **Michigan Participating Commercial Retail Pharmacies**.

Medicare Plus Blue℠ and BCN Advantage℠ members

For non-UAW Retiree Medical Benefits Trust members, Rite Aid and Walgreens offer lower copayments compared to standard pharmacies. Non-URMBT members who require assistance finding another pharmacy can use the following options:

- Transfer prescriptions to Optum Home Delivery by calling **1-855-810-0007**.
- Find a local pharmacy by using the **Find a Pharmacy webpage**.

URMBT members who require assistance finding another pharmacy can use the following options:

- Transfer prescriptions to Optum Home Delivery by calling **1-855-856-0537**.
- Find a local pharmacy by using the **Find a Pharmacy webpage**.

Q. How will pharmacies communicate closures to members?

A. Rite Aid and Walgreens may transfer prescription files to a nearby store of the same chain or sell the files to a different retail pharmacy. Communication methods about the closure and prescription transfer will vary. It may include store signage or texts, letters or emails to affected members.

Q. How can health care providers and their offices help members stay adherent to their medications when pharmacies close?

A. Providers can help members by:

- Confirming the patient's preferred pharmacy at every visit.
- When refilling prescriptions over the phone or by secure message, confirm the pharmacy, especially if it's Rite Aid or Walgreens.
- Encouraging patients to use the Optum mail-order pharmacy and remind them of the benefits of this service, such as 90-day supply, delivery right to their home and automatic refills.

Q. What are Blue Cross and BCN doing to ensure members stay adherent to their medications when pharmacies close?

A. We have a list of upcoming and completed pharmacy closures and members who have prescriptions at these locations. Our pharmacy team will notify and help those members find a new pharmacy, if needed.

Pharmacy News

2025 coverage change for GLP-1 drugs to treat obesity

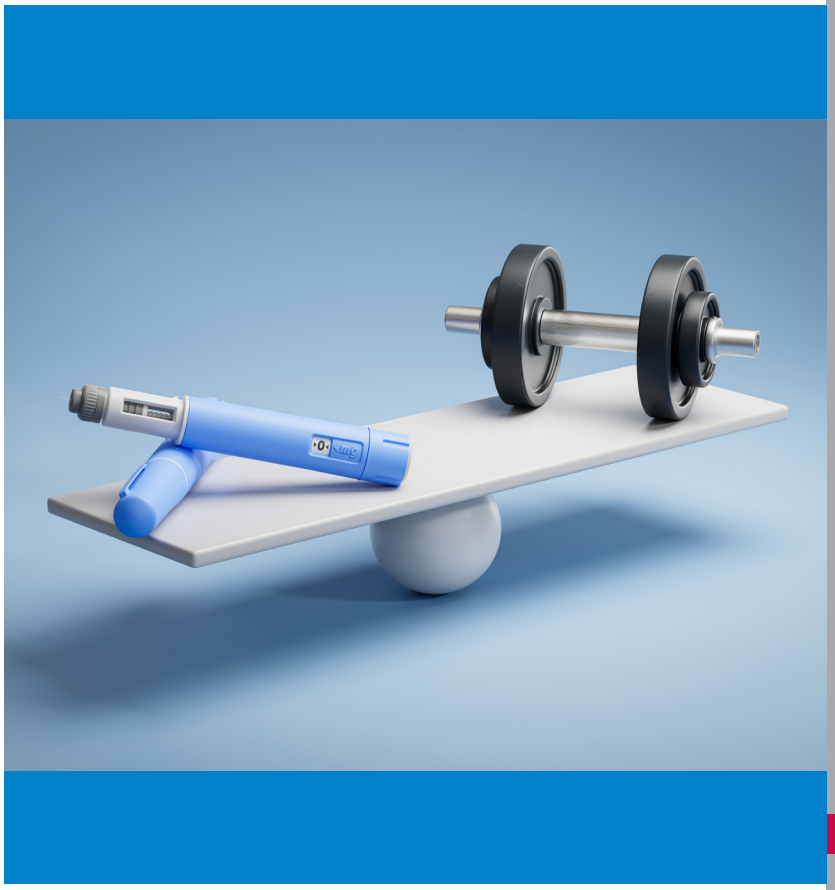
Beginning January 1, 2025, or on the group's 2025 health coverage renewal date, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover prescriptions for glucagon-like peptide-agonist drugs used for weight loss, including Saxenda®, Wegovy® and Zepbound®.

This change applies to Blue Cross and BCN commercial members of fully insured large groups with a prescription drug plan. If members decide to use these medications for weight loss in 2025, after the group's renewal date, they'll be responsible for the full cost. Impacted members will receive a letter prior to this change.

Some self-funded groups have removed coverage for these medications.

Additional information

Members can visit the websites for Saxenda, Wegovy and Zepbound to determine if they offer discount coupons. These medications may also be offered at a discount through GoodRx.



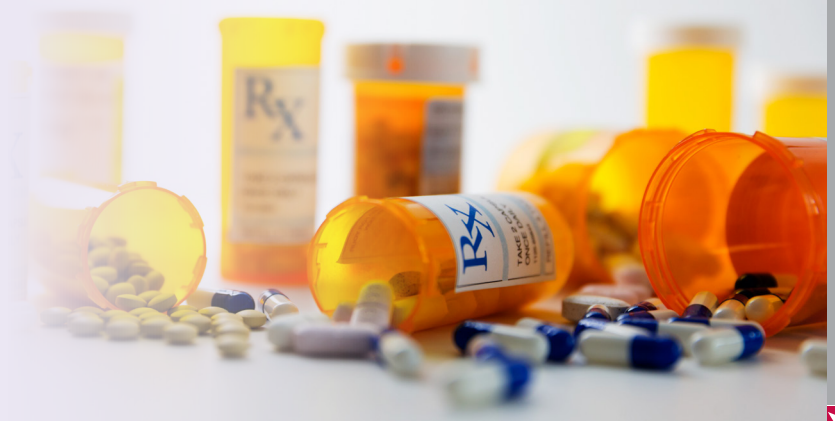
Requirements and codes changed for some medical benefit drugs

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

In July, August and September 2024, 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.



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Changes in requirements

For Blue Cross commercial and BCN commercial members: We added prior authorization requirements for the following drugs:

HCPCS code	Brand name	Generic name
J3590	Ahzantive™	Aflibercept-mrbb
J3590	Enzeevu™	Aflibercept-abzv
J3590	Epysqli®	Eculizumab-aagh
J3590	Kisunla™	Donanemab-azbt
J3590	Niktimvo™ IV	Axatilimab-csfr
J3590	Nypozi™ IV and SC	Filgrastim-txid
J3590	Pavblu™	Aflibercept-ayyh
J3590	PiaSky® IV and SC	Crovalimab-akkz
J3590	Pyzchiva® IV and SC	Ustekinumab-ttwe
J3590	Rytelo™	Imetelstat
J3590	Tecelra®	Afamitresgene autoleucel
J3590	Yimmugo IV	Immune globulin intravenous, human-dira

For Medicare Plus Blue℠ and BCN Advantage℠ members: We added prior authorization requirements to the following drugs:

HCPCS code	Brand name	Generic name	For dates of service on or after
J1747	Spevigo® SC	Spesolimab-sbzo	7/1/2024
J3590	Tyenne®	Tocilizumab-aazg	7/1/2024
J0175	Kisunla™	Donanemab-azbt	7/15/2024
J7699	Ohtuvayre™	Ensifentrine	7/15/2024
J9999	Rytelo™	Imetelstat	8/1/2024

Code changes

The table below shows HCPCS code changes that were effective July 2024 for the medical benefit drugs managed by Blue Cross and BCN.

New HCPCS code	Brand name	Generic name
J1748	Zymfentra™	Infliximab-dyyb
J2267	Omvoh™ IV	Mirikizumab-mrkz
J3247	Cosentyx® IV	Secukinumab
J3393	Zynteglo®	Betibeglogene autotemcel
J3394	Lyfgenia™	Lovotibeglogene autotemcel
J7171	Adzynma	ADAMTS13, recombinant-krhn
J9361	Ryzneuta®	Efbemalenograstim alfa-vuxw
J0175*	Kisunla™	Donanemab-azbt

*The J0175 code change is effective July 2, 2024. This aligns with the date Kisunla received approval from the U. S. Food and Drug Administration.

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**

Continued on following page

Pharmacy News

Additional information about these requirements

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

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

Additional information for Blue Cross commercial groups

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

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

Reminder

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

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

Tyenne, Tofidence and Zinplava to have a site-of-care requirement for most commercial members, starting Nov. 1

For dates of service on or after Nov. 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 drugs when they're billed under the medical benefit:

- Tyenne® IV and SC (tocilizumab-aazg), HCPCS code J3590
- Tofidence™ (tocilizumab-bav), HCPCS code Q5133
- Zinplava (bezlotoxumab), HCPCS code J0565

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for these drugs. If the request meets the 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

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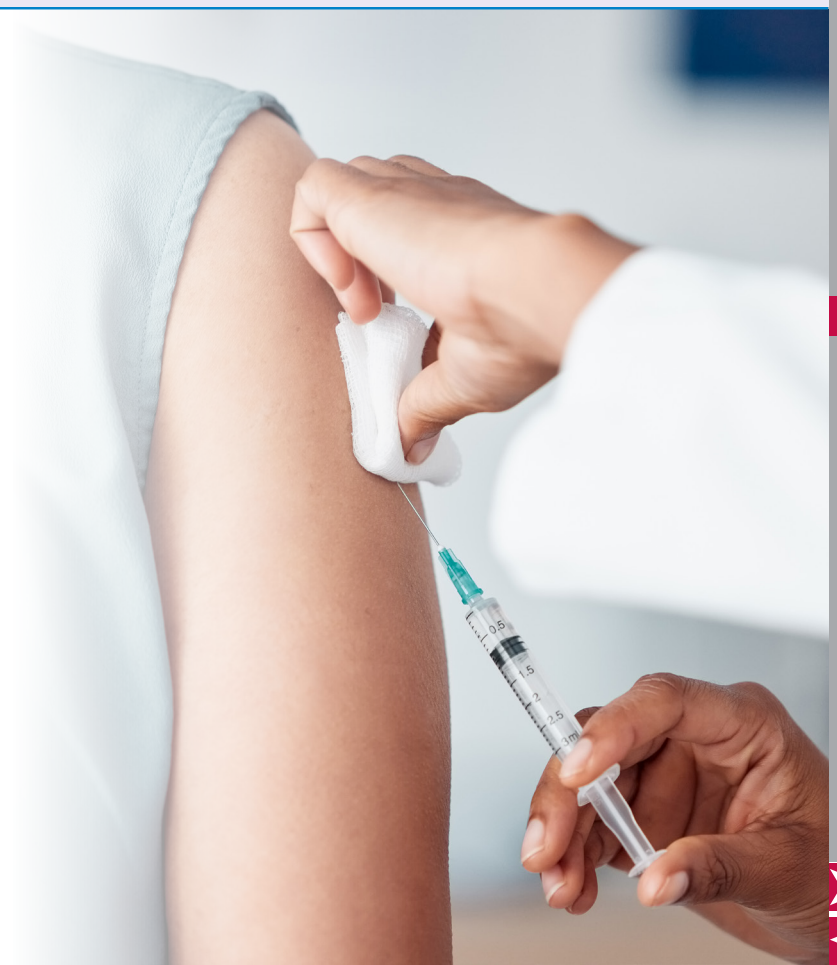

Pharmacy News

Additional information or documentation may be required for requests to administer Tyenne, Tofidence and Zinplava in an outpatient hospital setting.

As a reminder, these drugs already require prior authorization. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who start courses of treatment with Tyenne, Tofidence and Zinplava before Nov. 1, 2024, will be able to continue receiving the drug in their current location until their existing authorization expires. If these members then continue treatment under a new prior authorization, the site-of-care requirement outlined above will apply.

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

For Blue Cross commercial groups, 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**, at these locations:

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

Reminder

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

Blue Cross, BCN cover additional RSV vaccine

To increase access to vaccines and decrease the risk of vaccine-preventable disease outbreaks, Blue Cross Blue Shield of Michigan and Blue Care Network have added the following to our list of vaccines covered under pharmacy benefits.

Common Name	Vaccine	Effective date
Respiratory syncytial virus (RSV)	mRESVIA®	September 1, 2024

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 member out-of-pocket cost.

Continued on following page

Vaccines with age requirements

Common Name	Vaccine
Human Papillomavirus Vaccine (HPV)	Gardasil 9® 9 to 45 years old

Vaccines with no age requirements

Common Name	Vaccine
COVID-19 (1vCOV-aPS)	Novavax®
COVID-19 (1vCOV-mRNA)	Comirnaty®/Pfizer-BioNTech Spikevax®/Moderna
Dengue (DEN4CYD)	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis (DTaP)	Daptacel® Infanrix®
DTaP and inactivated poliovirus (DTaP-IPV)	Kinrix® Quadracel®
DTaP, hepatitis B, and inactivated poliovirus (DTaP-HepB-IPV)	Pediarix®
DTaP, inactivated poliovirus, and Haemophilus influenza type b, (DTaP-IPV-Hib)	Pentacel®
DTaP, inactivated poliovirus, Haemophilus influenza type b, hepatitis B (DTaP-IPV-Hib-HepB)	Vaxelis®
Haemophilus influenza type b (Hib PRP-OMP)	PedvaxHIB®
Haemophilus influenza type b (Hib PRP-T)	Act HIB® Hiberix®
Hepatitis A (HepA)	Havrix® Vaqta®
Hepatitis A and B (HepA-HepB)	Twinrix®
Hepatitis B (HepB)	Engerix-B® Heplisav-B® PreHevbrio™ Recombivax HB®
Influenza virus	Influenza vaccine (flu)
Measles, mumps, rubella (MMR)	M-M-RII® Priorix®
Measles, mumps, rubella and varicella (MMRV)	ProQuad®
Meningococcal serogroups A, C, W, Y (MenACWY-CRM)	Menveo®
Meningococcal serogroups A, C, W, Y (MenACWY-CRM)	Menveo®
Meningococcal serogroups A, C, W, Y (MenACWY-TT)	MenQuadfi®
Meningococcal serogroups A, B, C, W, Y vaccine (MenACWY-TT/MenB-FHbp)	PenbrayaTM
Meningococcal serogroup B (MenB-4C)	Bexsero®
Meningococcal serogroup B (MenB-FHbp)	Trumenba®
Mpox	Jynneos®
Pneumococcal conjugate (PCV15)	Vaxneuvance™
Pneumococcal conjugate (PCV20)	Prevnar 20™
Pneumococcal conjugate (PCV21)	Capvaxive™
Pneumococcal polysaccharide (PPSV23)	Pneumovax23®
Poliovirus (IPV)	Ipol®

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Respiratory syncytial virus (RSV)	Abrysvo™ Arexvy® mRESVIA®
Respiratory syncytial virus monoclonal antibody (RSV-mAB)	Beyfortus™
Rotavirus (RV1)	Rotarix®
Rotavirus (RV5)	RotaTeq®
Tetanus and diphtheria (Td)	TdVax® Tenivac®
Tetanus, diphtheria, and acellular pertussis (Tdap)	Adacel® Boostrix®
Varicella (VAR), chickenpox	Varivax®
Zoster (RZV), shingles	Shingrix®

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.

Rituximab preferred agents to change for Medicare Advantage members, starting Jan. 1

For dates of service on or after Jan. 1, 2025, Medicare Plus Blue and BCN Advantage are making changes to the preferred and nonpreferred designations for rituximab drugs.

Preferred agents

Preferred rituximab agents will be:

- Ruxience® (rituximab-pvvr), HCPCS code Q5119
- Riabni® (rituximab-arrx), HCPCS code Q5123

These preferred drugs will not require prior authorization.

Nonpreferred agents

Nonpreferred rituximab agents will be:

- Rituxan® (rituximab), HCPCS code J9312
- Truxima® (rituximab-abbs), HCPCS code Q5115

Submit prior authorization requests through the NovoLogix® online tool when these drugs will be billed as a medical benefit.

Continued on following page

Pharmacy News

When prior authorization is required

The nonpreferred agents will require prior authorization when 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 NovoLogix

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

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

List of requirements

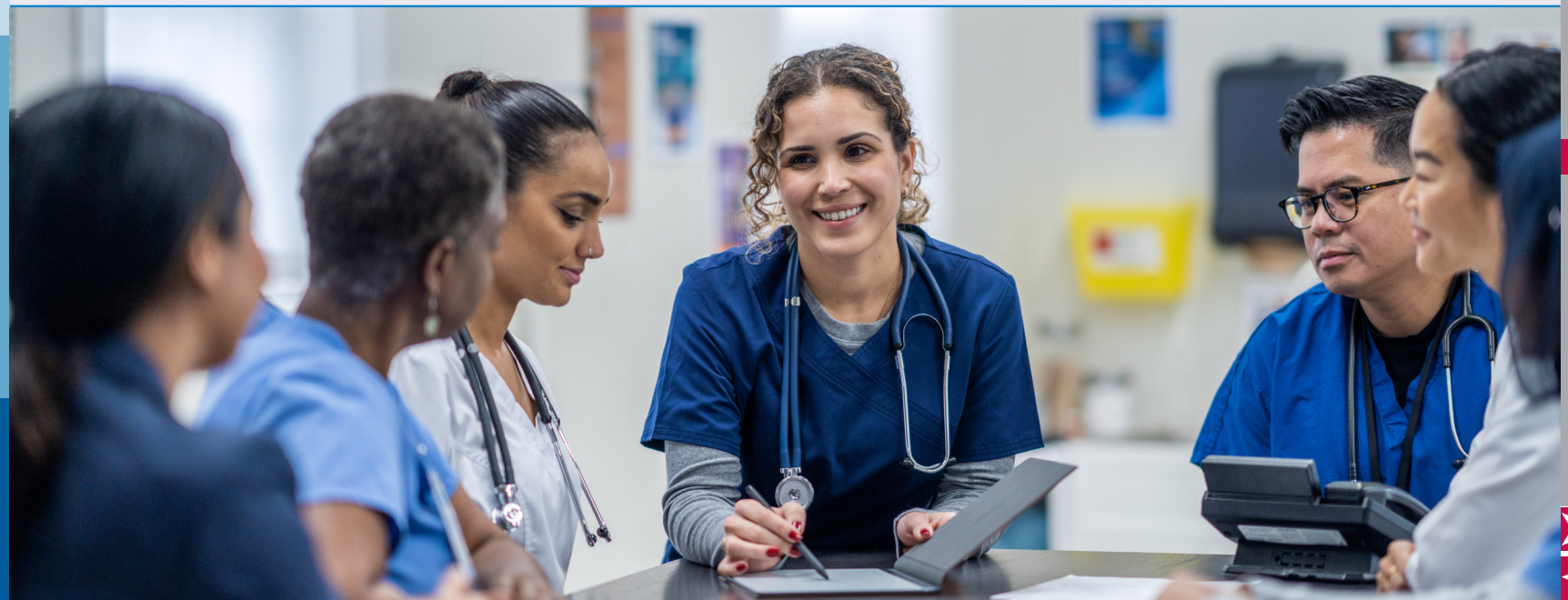
For a list of requirements related to drugs covered under the medical benefit, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**.

We'll update this 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.

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

- *Medicare Advantage members must obtain continuous glucose monitor products through a pharmacy, starting Oct. 1,* **Page 9**
- *Preferred immune globulin products for Medicare Advantage members to change, starting Nov. 1,* **Page 10**
- *Upcoming 2025 Medicare Advantage, Part D formulary changes may require prescribing alternative drugs,* **Page 11**



Billing Bulletin

Follow these guidelines for billing split or shared visits

We have noticed that members who are involved in physical therapy, occupational therapy, speech therapy and applied behavior analysis are sometimes receiving two or more of these therapies in the same time interval.

As a result, we're providing guidelines for how to bill when more than one therapy provider has provided services to the same Blue Cross Blue Shield of Michigan or Blue Care Network member during the same time interval — for example, from 1 to 2 p.m. on a specific day.

For our commercial members

For Blue Cross and BCN commercial members:

- The only time that two or more therapy providers can bill services for the same commercial member during the same time interval is when the procedure code definition allows for it.
- When the code definition doesn't indicate that split or shared billing is appropriate, the provider who spent the most amount of time with the member is the only provider who is permitted to bill. In other words, when physical therapy, occupational therapy, speech therapy and applied behavior analysis are provided during the same interval, only the provider who spent the most amount of time with the member can bill for that interval.

This applies to but isn't limited to procedure codes *97153, *97155, *0362T and *0373T.

For our Medicare Advantage members

For our Medicare Plus Blue℠ and BCN Advantage℠ members, follow the Centers for Medicare & Medicaid Services billing guidelines.

For all members

Providers are not prohibited from seeing a member at different times during the same day and billing for services. For example, if a patient receives an hour of physical therapy in the morning and an hour of occupational therapy in the afternoon, both providers can bill because the services occurred in different time intervals. This applies to all of our members.

Tips when billing E/M with preventive services

What you need to know

To improve the patient experience, let the patient know when a preventive encounter may be expanding to include treatment that could result in costs to the patient. Explaining this up front will save you from patient complaints later.

Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans recently began reimbursing evaluation and management, or E/M, services at 50% of the allowed amount when billed on the same day as a preventive service. This was effective with dates of service beginning June 1, 2024, and was announced in the **June 2024 issue of *The Record*** and the **July-August 2024 issue of *BCN Provider News*, Page 29**.

Since June, some members have complained about being charged a copay, coinsurance or deductible following their preventive service when an E/M service was also billed. To maintain a positive member experience, Blue Cross and BCN recommend the following:

- **Inform the patient when adding the E/M service**

  During a preventive service encounter, the practitioner should let the patient know when an additional service is going to be considered not preventive and potentially result in cost to the member. Then the patient can decide whether to proceed with that service.

- **Explain that combining the service could possibly save them money**

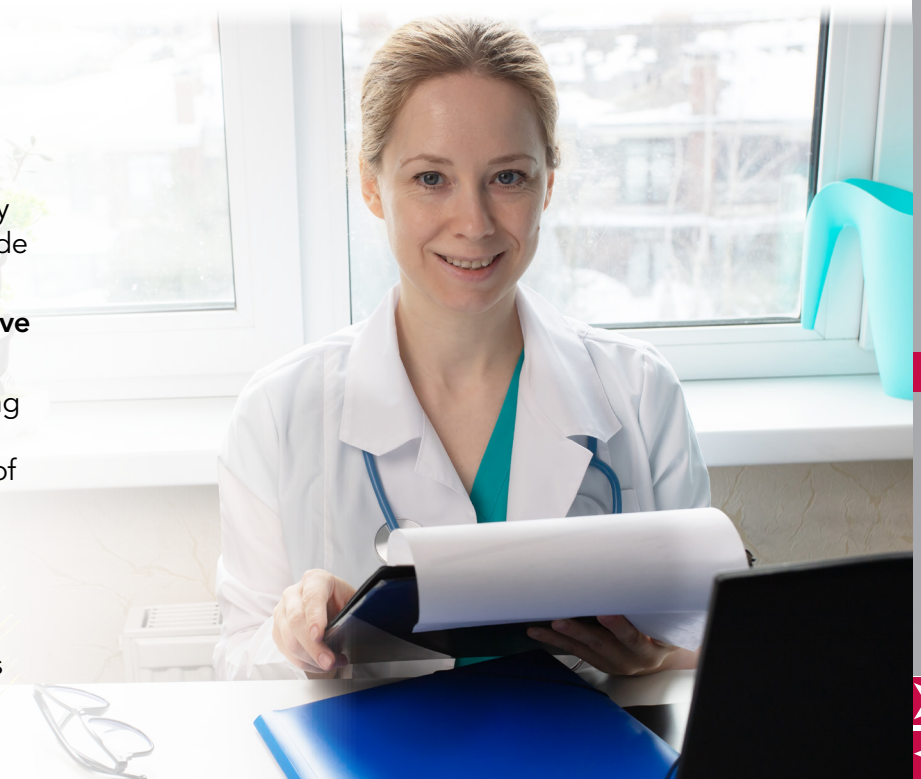
  If the patient has coinsurance or a deductible, combining the service with the preventive service could save the patient money. Since the service is reimbursed at 50% of the allowed amount, out-of-pocket cost that's based on the service cost will also be lower.

- **Let the patient know that two services will be billed**

  If the patient goes forward with the additional service, you should explain that the patient will see two services billed – one for the preventive service with no out-of-pocket cost and one for the medical examination for the additional service, which may require a copay, coinsurance or a deductible, depending on the patient's benefits.

A few notes

- Members with fixed dollar copays will usually pay the same copay if the E/M service is provided on the same day as a preventive service. The only time the fixed dollar copay would be reduced is if 50% of the allowed amount for the E/M service is less than the member's copay. In such a case, the member would pay the lower amount.
- Providers who are paid via capitation for BCN will not receive additional reimbursement as these E/M codes and preventive services are included in capitation payments.
- Our Medicare Advantage plans, Medicare Plus Blue℠ and BCN Advantage℠, reimburse E/M on the same day as preventive services in alignment with Medicare rules.



Billing Bulletin

BCN Provider *News*

Feedback

Quality MINUTE

Blue Cross Blue Shield Blue Care Network of Michigan

An ongoing series of quick tips designed to be read in 60 seconds or less and provide your practice with information about performance in key areas.

Hierarchical Condition Category (HCC) Coding Persistency

- Persistency is the recapture of chronic diagnoses year over year for risk adjustment purposes.
- Blue Cross Blue Shield of Michigan sends an HCC coding list to Edifecs mailboxes on the first Thursday of every month that can be utilized to identify possible diagnoses for risk capture.
- Pre-visit chart prep is a key strategy to recapturing chronic disease codes. This includes reviewing the medical record for current/past chronic conditions, problem list, and consultations/discharge summaries for potential new conditions.
- All documented conditions that co-exist at the time of the visit and that require or affect patient care, treatment and management should be coded.
- It is important to ensure you are capturing your patients' complete and accurate full burden of illness.

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.

Clinical Editing Billing Tips

This issue's tips:

- Coding for facility and professional claims
- Do not send a new claim, send a corrected claim

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

Referral Roundup

Reminder: Home health care services no longer require prior authorization for Medicare Advantage members

As we announced in a **July 2, 2024, provider alert**, home health care services for Medicare Advantage members no longer require prior authorization starting Oct. 1, 2024.

For claims that were submitted on or after Oct. 1, 2024, our systems won't look for an approved prior authorization. In addition, we won't accept retroactive authorization requests.

Our provider manuals and related documents have been updated to reflect these changes.

Reminders:

- As part of our commitment to deliver care in line with standards set by the Centers for Medicare & Medicaid Services, we'll continue to monitor compliance with these standards through claims review, post-payment audits and strategic collaboration with health care providers who are in shared- and full-risk arrangements.
- Be sure to check each member's eligibility and benefits prior to performing services.

Prior authorization changes for blepharoplasty, enteral nutrition, percutaneous left atrial appendage and varicose vein treatment

For dates of service on or after Sept. 8, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network changed the prior authorization process for the following services for the lines of business listed in the second column of the table.

Service	Affected lines of business	What happened before Sept. 8	What happens now
Blepharoplasty	Medicare Plus Blue℠ BCN Advantage℠	The **standard** questionnaire, titled *Blepharoplasty and repair of brow ptosis (outpatient)*, opened in the e-referral system for procedure codes *15822, *15823, *67900, *67901, *67902, *67903, *67904, *67906 and *67908.	For the procedure codes listed at left, **custom** questions will open in the e-referral system for Medicare Plus Blue and BCN Advantage members. The questions vary by procedure code and are based on the Medicare guideline titled *Blepharoplasty, Blepharoptosis and Brow Lift WPS*. **Note**: For BCN commercial, there's no change. The **standard** questionnaire continues to open.
Enteral nutrition	BCN commercial BCN Advantage	A **standard** questionnaire, titled *Enteral nutrition*, opened in the e-referral system for procedure codes B4102, B4103, B4104, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9002 and B9998.	• We retired the **standard** questionnaire for BCN commercial and BCN Advantage. • For the procedure codes listed at left, **custom** questions open in the e-referral system. The questions vary by procedure code and: - For BCN commercial, are based on our *Enteral Nutrition* medical policy. - For BCN Advantage, are based on the Medicare guideline titled *Enteral Nutrition CGS Administrators*.

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Service	Affected lines of business	What happened before Sept. 8	What happens now
Percutaneous left atrial appendage closure	Medicare Plus Blue BCN Advantage	A **standard** questionnaire, titled *Left atrial appendage closure*, opened in the e-referral system for procedure code *33340.	For the procedure code listed at left, **custom** questions open in the e-referral system for Medicare Plus Blue and BCN Advantage members. The questions vary by procedure code and are based on the Medicare guideline titled *Percutaneous Left Atrial Appendage Closure (LAAC) NCD.* **Note**: For BCN commercial, there's no change. The **standard** questionnaire continues to open.
Varicose vein treatment	Medicare Plus Blue BCN Advantage	For Medicare Plus Blue, **custom** questions opened in the e-referral system for procedure codes *36473, *36474 and *36482. For BCN Advantage, **custom** questions opened in the e-referral system for procedure codes *36465, *36466, *36470, *36471, *36473, *36474, *36475, *36478, *36482, *37718, *37700, *37722, *37780, *37785 and S2202.	For the procedure codes listed at left, **different custom** questions open for Medicare Plus Blue and BCN Advantage. The questions are based on the Medicare guideline titled *Treatment of Varicose Veins of the Lower Extremities WPS.* **Note**: For BCN commercial, there's no change. The **same custom** questions continue to open and are based on our *Treatment of Varicose Veins/Venous Insufficiency* medical policy.

We updated the **Authorization criteria and preview questionnaires** document on **ereferrals.bcbsm.com** to reflect these changes.

Training is also available. To view the training:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *Provider Training Site* tile in the Applications tab.
4. Select an organization and click *Submit*.
5. Enter *InterQual* in the search bar and press *Enter*.
6. Open the *InterQual criteria in e-referral mini module*.
7. Launch the course.

Referral Roundup

Learn more about changes related to post-acute care services for Medicare Advantage members

In a **May 15, 2024, provider alert**, we announced that Home & Community Care (formerly known as naviHealth, Inc.) will no longer manage prior authorizations of post-acute care services for Medicare Plus Blue℠ and BCN Advantage℠ members starting this fall. Instead, Blue Cross Blue Shield of Michigan and Blue Care Network will manage prior authorizations for these services.

This change took effect on Oct. 1, 2024. For dates of service **on or after** Oct. 1, submit prior authorization requests to Blue Cross or BCN through the e-referral system, which is accessible through our provider portal, Availity Essentials™. Note that patient-driven payment model, or PDPM, codes aren't required for prior authorization requests for skilled nursing facility services for dates of service on or after Oct. 1. (If you've been submitting requests through CarePort Care Management, keep reading for more information.)

Notes:

- Be sure to include Centers for Medicare & Medicaid Services-generated PDPM code on claims for skilled nursing facility services. We'll continue to perform post-payment audits for PDPM codes and other billing requirements.
- For retroactive authorization requests with dates of service on or before Sept. 30, submit requests to Blue Cross or BCN through the e-referral system. Be sure to enter the Centers for Medicare & Medicaid Services-determined PDPM code in the *Case Communication* field. We'll accept retroactive requests through Sept. 30, 2025. If you have questions, send them to **UMMedicarePACCA@bcbsm.com**.

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Training resource

To access the recorded webinar about this change, log in to the Provider Training site and search on *post-acute care*. Look for the following recorded webinar: *Medicare Advantage Post-Acute Care Prior Authorization Program*.

To access the Provider Training site:

1. Log in to our provider portal (**availity.com**).
2. Click on *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click on the *Provider Training Site* tile in the *Applications* tab.
4. Select an organization and click *Submit*.

For issues regarding access to or navigating the site, email **ProviderTraining@bcbsm.com**.

If you've been submitting requests through CarePort Care Management

As of Oct. 1, you can no longer submit prior authorization requests for post-acute care services through CarePort Care Management. You need to log in to our provider portal, Availity Essentials, and submit prior authorization requests through the e-referral system, as you do for prior authorization requests for other services (such as inpatient admissions and post-acute care requests for commercial members).

For information about submitting prior authorization requests in the e-referral system, refer to the **e-referral User Guide**. (See "Section IV: Referrals and Authorizations," and look for the subsection titled "Submit an Outpatient Authorization.")

Additional information

Our provider manuals and related resources have been updated to reflect this change.

For information about post-acute care, see the post-acute care pages on our **ereferrals.bcbsm.com** website.

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

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

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

- *Preferred immune globulin products for Medicare Advantage members to change, starting Nov. 1,* **Page 10**
- *Update on the Oncology Value Management program through OncoHealth,* **Page 17**
- *Register for a live webinar about the Oncology Value Management program through OncoHealth,* **Page 18**
- *Requirements and codes changed for some medical benefit drugs,* **Page 21**
- *Tyenne, Tofidence and Zinplava to have a site-of-care requirement for most commercial members, starting Nov. 1,* **Page 23**
- *Rituximab preferred agents to change for Medicare Advantage members, starting Jan. 1,* **Page 26**

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