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JANAUARY–FEBRUARY 2024

BCN Provider News

Blue Cross and BCN receive 4-Star Ratings from CMS

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

Star Ratings are CMS' measure of how well health plans serve MA members. They're designed to evaluate how well plans that contract with Medicare perform, and to help consumers select a Medicare Advantage plan that works best for them.

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

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

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

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

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

Continued on following page

Inside this issue…

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JANAUARY–FEBRUARY 2024

BCN Provider News

A deeper dive into the ratings

Medicare considers five categories when assigning Star Ratings:

- Maintaining health for members, including benefits such as cancer screenings and vaccines
- Managing chronic conditions, such as diabetes and blood pressure
- Customer service, including how responsive the plan is, as well as the quality of care that people with the plan receive
- Member complaint reports, which include problems in getting services and decisions on appeals
- Member experience with their plan, quality of care received and access to care

Blue Cross' 4-Star ratings for 2024 reflect sustained performance in several key areas, including HEDIS® measures** and CAHPS® surveys.*** The Consumer Assessment of Healthcare Providers and Systems surveys, developed by the Agency for Healthcare Research and Quality, evaluate a member's experience with their plan, quality of care received and access to care.

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

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

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Network Operations

Office staff can join Provider Advisory Panel

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

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

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

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

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

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

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

Network Operations

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

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

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

Specific provider networks are associated with these plans.

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

Keep reading to learn the details.

Starting Oct. 1, 2023

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

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

Before Oct. 1, 2023

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

Additional information

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

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

Network Operations

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

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

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

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

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

- BCN point of service health plan plastic member ID cards feature the BCN logo as well as the health plan name, which includes "POS" (for example, Blue Elect Plus℠ POS, Healthy Blue Choices℠ POS).
- The back of BCN point of service health plan plastic member ID cards have a statement saying the POS plan doesn't require a referral.
- When you check member eligibility and benefits in our provider portal, through an electronic transaction or by calling Provider Inquiry, you'll receive a message stating that the member can self-refer to any provider for covered services with no referral required.

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

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

Network Operations

Where to view provider portal change and status updates

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

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

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

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

To view this document:

1. Log in to our provider portal (**availity.com**).
2. Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
3. Click on the *News and Announcements* tab.
4. Click on the *Provider Portal Change and Status Updates (PDF)* link.

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

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

Action Item

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

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

To access the training site, follow these steps:

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

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

For new training site users:

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

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

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

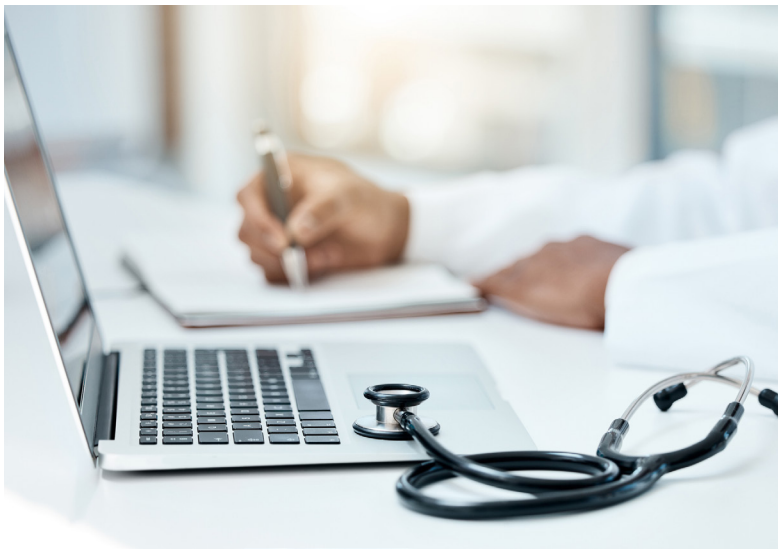
New learning path on provider training website

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

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

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

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.



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

Action Item

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

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

We recently updated or added the following learning opportunities:

- *Health e-Blue video tutorial*

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

- Finding *BCN Qualification form for Healthy Blue Living*

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

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

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

To request access to the training site, complete the following steps:

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

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

Network Operations

Blue Care Network fee schedule update reminder

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

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

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

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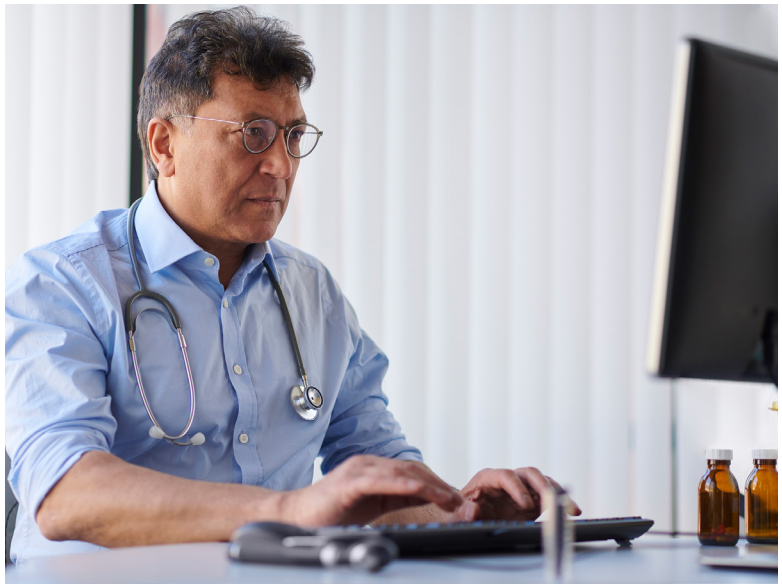


Here are some other articles in this issue that may be of interest

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

BCN Advantage

Get ready for 2024 annual Medicare wellness visits

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

Welcome to Medicare visit

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

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

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

Enhanced annual wellness visit

After having Medicare Part B for longer than 12 months, members can get an annual wellness visit every 12 months to develop or update a personalized prevention plan based on their current health and risk factors. They can get the enhanced annual wellness visit anytime throughout a calendar year, regardless of the date of the previous year's visit. No out-of-pocket cost applies.

BCN Advantage

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

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

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

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

Diabetes, hypertension and weight management solutions

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

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

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

Continued on following page

What's changing

Members will access these solutions through the Teladoc app.

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

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

We're updating our communications to reflect these changes.

Additional information

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

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

Virtual Care replacing Blue Cross Online Visits in January

What you need to know

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

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

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

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

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

Urgent care

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

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

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

Continued on following page

Mental health care

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

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

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

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

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

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

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

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

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

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

Continued on following page

Completing the qualification form

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

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click the *BCBSM* and *BCN logo*.
3. Click the *BCN Qualification Form (for Healthy Blue Living)* on the Applications tab. This takes you to Health e-Blue.
4. Select "Panel – Healthy Blue Living" in the side bar to complete the form.

Billing for the qualification form and exam

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

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

Learn more about Healthy *Blue* Living

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

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

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

To find the above resources using Health e-Blue:

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click the *BCBSM* and *BCN logo*.
3. Click *Health e-Blue – BCN* on the *Applications* tab.
4. Scroll down to *Resources* and locate the form under the *Healthy Blue Living Supporting Documents* section.

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

1. Follow the first two steps above.
2. Click the *Resources* tab.
3. Click *Secure Provider Resources (Blue Cross and BCN)*.
4. Click on the drop-down menu next to *Products* on the menu bar and click *BCN*.
5. Scroll down to the Healthy *Blue* Living section. You can also choose the *Forms* drop-down menu, select *Products*, then *Blue Care Network Commercial and Healthy Blue Living*.

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.

Patient Care/ Quality

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

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

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

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

Note: Because of variations in coverage, it's always best to check benefits and eligibility for your patients on our provider portal (availity.com).

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

Updated COVID-19 vaccines approved by FDA

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

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

For more information, see the following:

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

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

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

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

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

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

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

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

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.

Learn more about the Cancer Support program for commercial members

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

- Members who have coverage through Blue Cross and BCN commercial fully insured groups
- Commercial members who have individual coverage
- Members who have coverage through self-funded commercial groups that purchase the program

This program will help adult members navigate the emotional, physical and financial challenges caused by cancer diagnosis and treatment. It also aims to lower the burden on health care providers and **complement** — not replace or interfere with — the care they provide.

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

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

To access the FAQ, click the link provided or:

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

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

Medical policy updates

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

1. Go to **bcbsm.com/providers**.
2. Click *Resources* in the top navigation.
3. Click the *Search Medical Policies* button.

Medical Policy Updates

Recent updates to the medical policies include:

Covered services

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

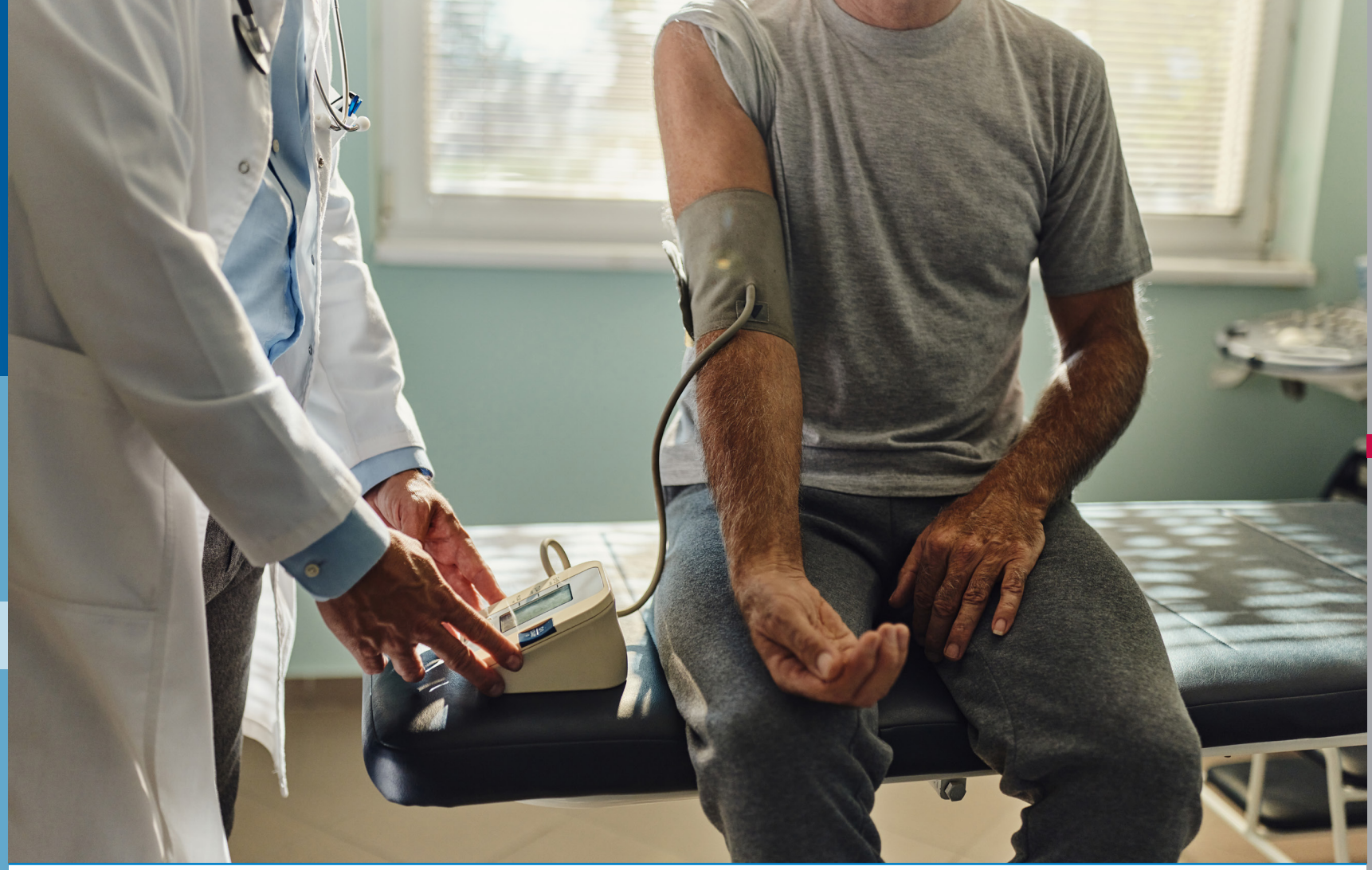
Noncovered services

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

Established

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

Patient Care/ Quality



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

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

Behavioral Health

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

From the medical director

By Dr. William Beecroft

Dr. Beecroft is medical director of behavioral health for Blue Cross Blue Shield of Michigan and Blue Care Network

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

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

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

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

Continued on following page

Behavioral Health

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

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

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

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Kieu, A. (2021). Now More Than Ever, Mental Health Care Needs Family Medicine. Family Practice Management 28(3): 11A-11C. Retrieved from https://aafp.org.

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

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

Starting Jan. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will consolidate the prior authorization and case management functions for behavioral health services, including treatment for autism.

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

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

Continued on following page

Find details in the FAQ

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

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

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

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

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

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

Pharmacy News

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

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

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

Drugs that will change on the Preferred Drug List

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional information

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

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

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

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

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

- Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc), HCPCS code J3590

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for this drug. If the request meets clinical criteria for the drug and is for one of the following sites of care, it will be approved automatically:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

Additional information or documentation may be required for requests to administer Vyvgart Hytrulo in an outpatient hospital setting.

As a reminder, this drug already requires prior authorization; providers can submit prior authorization requests using NovoLogix®. The new site-of-care requirement is in addition to the current prior authorization requirement.

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

Some Blue Cross commercial groups not subject to these requirements

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

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

List of requirements

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

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

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

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

Pharmacy News

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

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

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

Administration site and coverage details

Beyfortus is covered as follows:

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

Continued on following page

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

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

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

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

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

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

Blue Cross and BCN are covering additional vaccines

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

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

Continued on following page

Pharmacy News

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

Vaccines that have an age requirement

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

Vaccines that have no age requirement

Vaccine	Common name and abbreviation
• Dengvaxia®	Dengue vaccine — DEN4CYD
• Daptacel® • Infanrix®	Diphtheria, tetanus, and acellular pertussis vaccine — DTaP
• Diphtheria and tetanus toxoids	Diphtheria, tetanus vaccine — DT
• Kinrix® • Quadracel®	DTap and inactivated poliovirus vaccine — DTaP-IPV
• Pediarix®	DTaP, hepatitis B, and inactivated poliovirus vaccine — DTaP-HepB-IPV
• Vaxelis®	DTaP, inactivated poliovirus, Haemophilus influenzae type b, and hepatitis B vaccine — DTaP-IPV-Hib-HepB
• ActHIB® • Hiberix® • PedvaxHIB®	Haemophilus influenzae type b vaccine — Hib
• Havrix® • Vaqta®	Hepatitis A — HepA
• Engerix-B® • Heplisav-B® • PreHevbrio™ • Recombivax HB®	Hepatitis B — HepB

Continued on following page

Vaccine	Common name and abbreviation
• Twinrix®	Hepatitis A & B — HepA-HEPB
• M-M-R II® • Priorix®	Measles, mumps, rubella vaccine — MMR
• ProQuad®	Measles, mumps, rubella and varicella vaccine — MMRV
• Menveo®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-CRM
• Menactra®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-D
• MenQuadfi®	Meningococcal serogroups A, C, W, Y vaccine — MenACWY-TT
• Bexsero®	Meningococcal serogroup B vaccine — MenB-4C
• Trumenba®	Meningococcal serogroup B vaccine — MenB-FHbp
• Vaxneuvance™	Pneumococcal 15-valent conjugate vaccine — PCV15
• Prevnar 20™	Pneumococcal 20-valent conjugate vaccine — PCV20
• Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine (PPSV23)
• IPOL®	Poliovirus (IPV)
• Arexvy™ • Abrysvo™ • Beyfortus™	Respiratory syncytial virus (RSV)
• Rotarix®	Rotavirus vaccine (RV1)
• RotaTeq®	Rotavirus vaccine (RV5)
• Tdvax® • Tenivac®	Tetanus and diphtheria vaccine (Td)
• Adacel® • Boostrix®	Tetanus, diphtheria and acellular pertussis vaccine (Tdap)
• Varivax®	Varicella vaccine (VAR) (chickenpox)
• Shingrix®	Zoster vaccine (RZV) (Shingles)

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

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

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

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

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

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

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

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

Some Blue Cross commercial groups not subject to these requirements

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

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

Additional information

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

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

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

Pharmacy News

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

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

These changes will affect:

- Most Blue Cross commercial members

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

Changes to preferred drug designations

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

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

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How existing prior authorizations are affected by these changes

Existing prior authorizations are affected as follows:

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

Changes to prior authorization processes

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

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

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

Additional information

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

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

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

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

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services. For more information, go to our **ereferrals.bcbsm.com** website.

Pharmacy News

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

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

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

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

Preferred drug designations are changing

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

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

Continued on following page

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

How to submit prior authorization requests

Submit prior authorization requests as follows:

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

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

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

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

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

When prior authorization is required

These drugs will require prior authorization when they're administered by a health care provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

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

List of requirements

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

We'll update the list to reflect these changes prior to the effective date.

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

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services. For more information, go to our ereferrals.bcbsm.com website.

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

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

Notes:

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

Requirements added for Cimzia and Skyrizi

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

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

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

Requirements removed for Ilumya

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

Ilumya will continue to require prior authorization.

How to submit prior authorization requests

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

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

When prior authorization is required

The drugs mentioned above require prior authorization when they are administered by a provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

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

List of requirements

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

We'll update the list to reflect these changes prior to the effective date.

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

Billing Bulletin

Know guidelines for trauma activation billing and reimbursement

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

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

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

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

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

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

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

Continued on following page

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

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

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

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

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

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

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

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

Additional information

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

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

Billing Bulletin

Blue Cross doesn't reimburse providers for bladder scanning

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

Background

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

Additional features now available for uploading medical records electronically

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

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

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

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

Register for a webinar about the new functionality

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

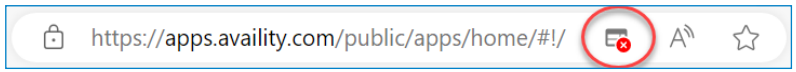
1. Log in to our provider portal (**availity.com**)

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

2. Click on the link below to register.

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

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



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

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

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

Reasons to upload medical records electronically

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

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

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

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

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

Continued on following page

Additional information

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

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

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.

Clinical editing billing tips

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

Clinical Editing Billing Tips

This issue's tips:

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

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

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

Referral Roundup

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

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

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

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

You must provide the following information:

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

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

If the required information isn't included when you submit the prior authorization request, the request is considered incomplete and can't be processed. We'll reach out to you and ask that you resubmit the request when the information is available. This delays the processing of the request.

Be aware that:

- The three SNFs must be contracted with Blue Cross or BCN and located within 75 miles of the facility in which the member is currently a patient.
- Two of the three SNFs must be facilities that can accommodate members who need higher levels of care, such as complex wound care or total parenteral nutrition.

You can read more about these and other requirements in the document **Blue Cross and BCN Local Rules for 2023 for post-acute care: Modifications of InterQual® criteria**.

You can access this document at **ereferrals.bcbsm.com**, on these webpages:

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

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

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

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

Criteria	Services
InterQual acute — Adult	• Inpatient admissions • Continued stay discharge readiness
InterQual acute — Pediatric	• Inpatient admissions • Continued stay discharge readiness
InterQual level of care — Subacute and skilled nursing facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual rehabilitation — Adult and pediatrics	• Inpatient admissions • Continued stay discharge readiness

How we'll use the updated criteria

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

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

When clinical information is requested for a medical or surgical admission or for other services, we require providers to submit specific components of the medical record that show that the request meets the criteria. We review this information when making determinations on prior authorization requests.

This information:

- Applies to lines of business and members whose authorizations are managed by Blue Cross or BCN directly and not by independent companies that provide services to Blue Cross Blue Shield of Michigan
- Doesn't apply to behavioral health services

No updates to our local rules

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

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

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

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

Facilities must submit appeals within required time frames

What you need to know

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

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

We reinstated the usual appeals time frames on July 1

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

Time frames for submitting appeals

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

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

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

Continued on following page

Where to find additional information

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

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

To access the provider manuals:

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

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.

Changes to prior authorization request process for varicose vein procedures

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

Keep reading to learn more.

Questions presented in e-referral system

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

- *Endovenous ablation for treatment of varicose veins*

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

- *Varicose vein treatment*

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

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

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

Continued on following page

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

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

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

How to access the updated medical policy

To view the updated medical policy:

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

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

New and updated questionnaires in e-referral system

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

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

New questionnaires

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

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

Continued on following page

Updated questionnaires

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

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

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time.

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

Authorization criteria and medical policies

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

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

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

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

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

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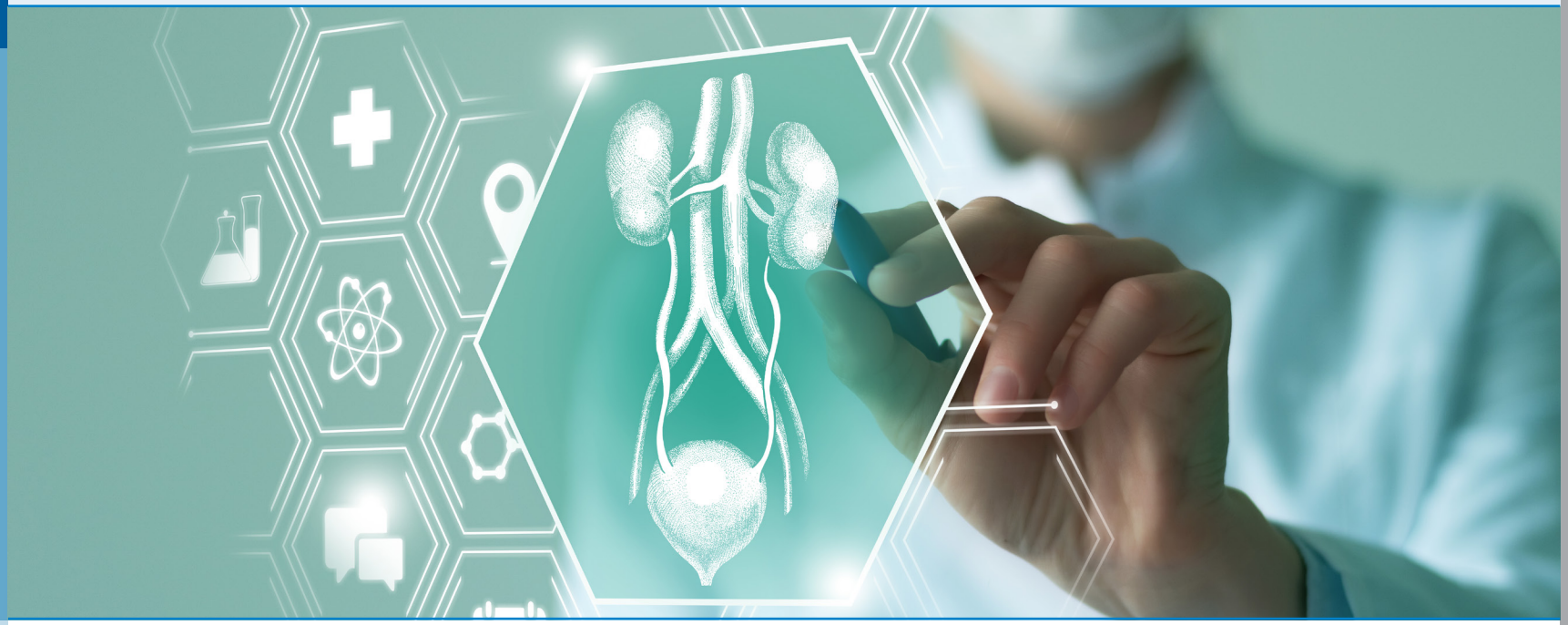
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by BCN)

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

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



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

For dates of service on or after Jan. 1, 2024, hospital transplant financial coordinators must submit prior authorization requests for kidney-only transplants through the e-referral system. This requirement applies to:

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

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

Referral Roundup

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

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

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

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

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

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

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

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

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

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Referral Roundup

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

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

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

- Less than two-midnight hospital admission

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

- Two-midnight admission

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

- Greater than two-midnight admission

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

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

In this communication, we're reaffirming that:

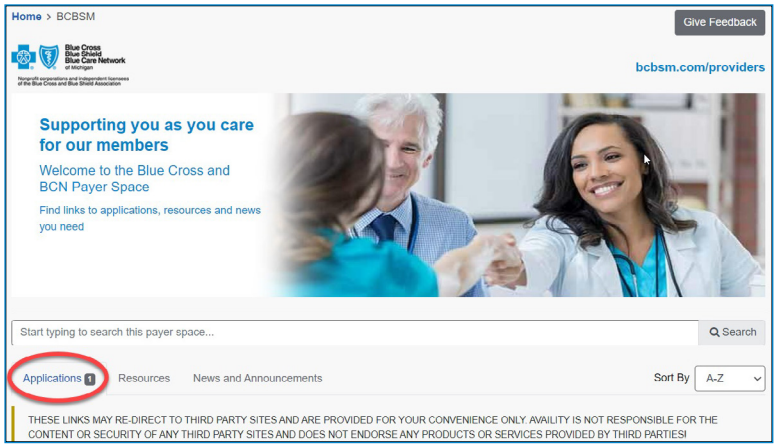
- Blue Cross and BCN will continue to use applicable evidence-based medical necessity criteria as part of our internal coverage criteria and Medicare coverage guidelines to make determinations on prior authorization requests for hospital admissions of our Medicare Advantage members.
- We require admitting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

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

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

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

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



Additional information available for providers

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

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

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

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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…

Network Operations

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

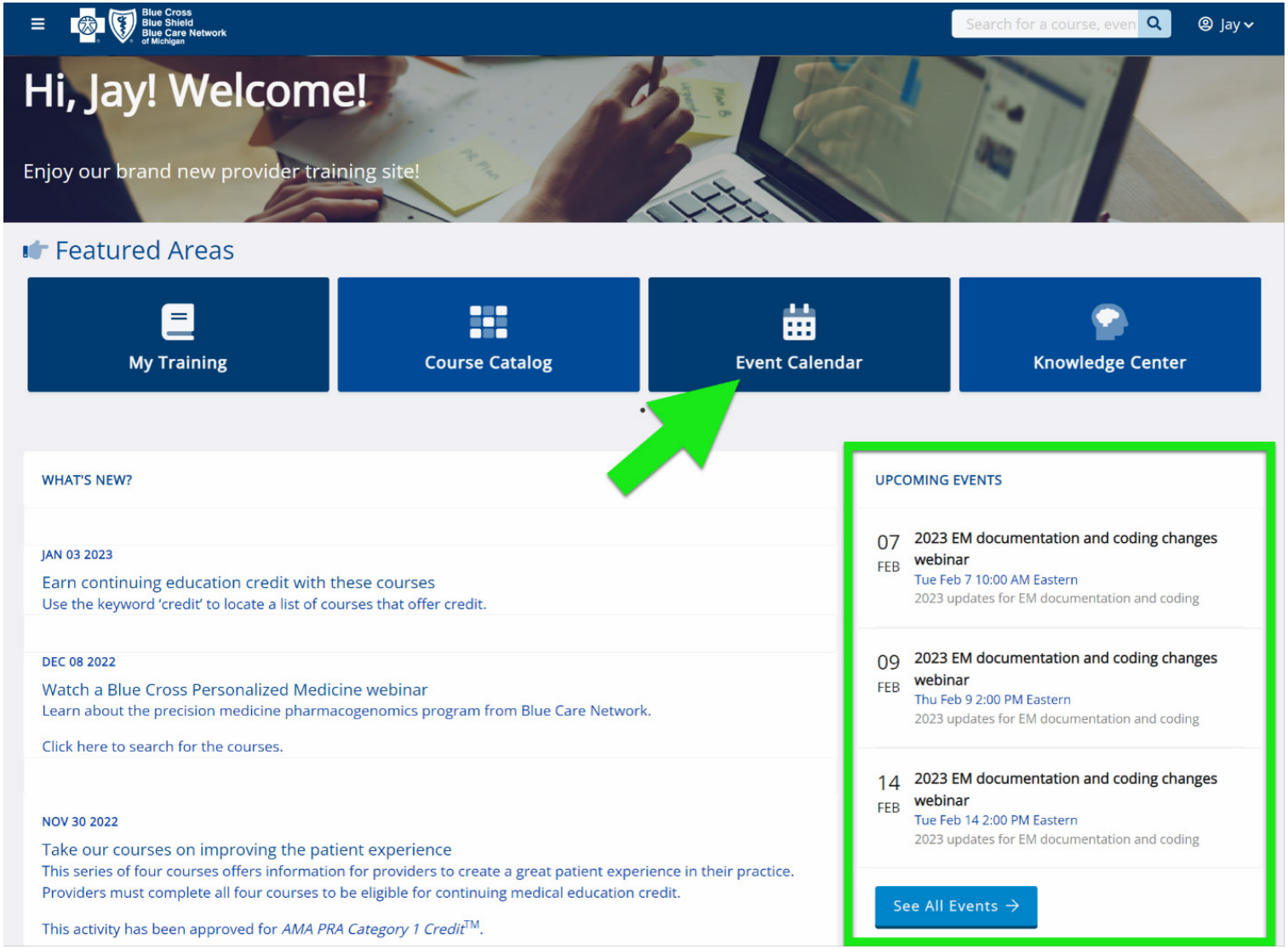
Provider training website access

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**.

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 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**.

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.

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

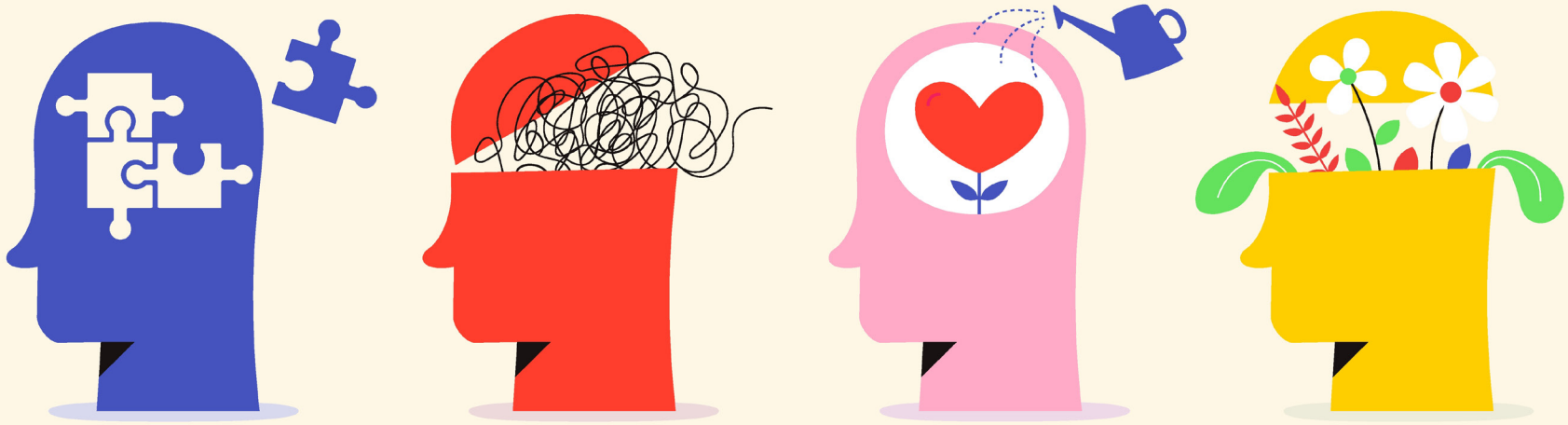
Mixed services

- 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



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:

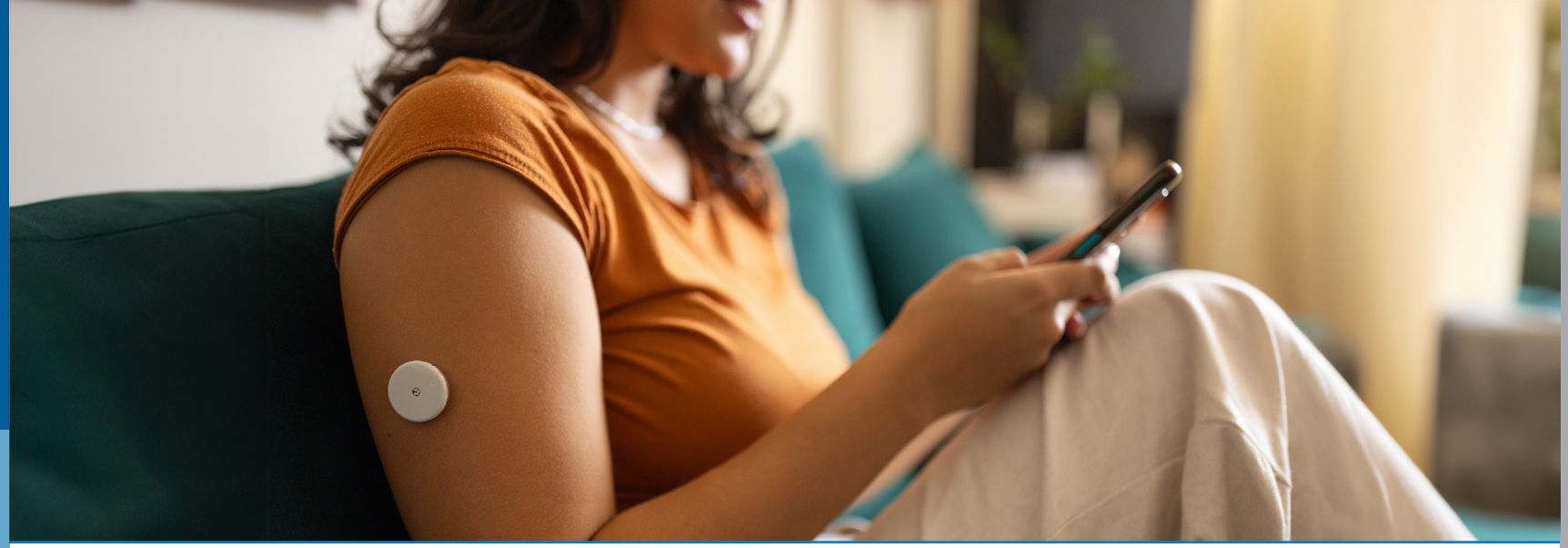
- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

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

Referral Roundup

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

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

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BCN Provider News

Practice caution with requests for patient information

Our Corporate and Financial Investigations Unit has been made aware of provider offices receiving fraudulent requests for patient information, provider NPI numbers and provider signatures. These requests, which may come to you by standard mail, email or fax, often include clues that indicate they are not legitimate; for example:

- The use of a generic "BlueCross BlueShield" logo; that is, not the official Blue Cross Blue Shield of Michigan, Blue Care Network, or Blue Cross and Blue Shield Association logo
- Obvious grammatical errors (wrong tense, misspelled words, random or inconsistent capitalization, etc.)
- Phone numbers that don't match

DME fraud is becoming more common

One of the largest health care fraud schemes of the past few years involves durable medical equipment, costing the health care industry tens of millions of dollars a year. Our Medicare members can be particularly susceptible to these schemes. For example, fraudulent telemarketers may reach out to seniors offering "free" durable medical equipment, intentionally trying to confuse them to get Medicare to pay for equipment that isn't actually vetted by a medical professional (and that the member often never receives).

If you suspect a request may be fraudulent, don't respond to it!

When we conduct mass requests for medical records or patient information, we often notify you through a provider newsletter article or a provider alert. If you're suspicious of a request, contact our Fraud Hotline at 1-844-STOP-FWA (1-844-786-7392) or send an email to **StopFraud@bcbsm.com**. We may ask you to share the request so we can check its legitimacy.

For more useful information, check out the **Victimized Provider Project section** of the Centers for Medicare & Medicaid website. The Victimized Provider Project helps keep providers from being held liable for overpayment of claims paid that are the result of identity theft.

By working together, we can help eliminate fraud, an effort that will improve patient safety and reduce costs.

Feedback | Subscribe

Inside this issue…

Network Operations

Confirm data every 90 days, attest in CAQH every 120 days

What you need to know

To remain listed in Blue Cross Blue Shield of Michigan's provider directories, including *Find a Doctor*, health care providers must re-attest every 120 days in CAQH.

Have you confirmed your data within the past 90 days and attested in CAQH within the past 120 days? Health care providers are required to confirm the following data elements every 90 days: name, specialty, address, phone number and digital contact information. Providers are also required to re-attest every 120 days for all other data elements, including credentialing, licensing and demographics.

If providers don't re-attest with CAQH every 120 days, they won't be included in Blue Cross Blue Shield of Michigan's provider directories, including our *Find a Doctor* search tool. Your credentialing status will end if you fail to re-attest, and you'll need to reapply.

It's important to attest with CAQH to:

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

Providers who practice at an office location or exclusively in an inpatient hospital setting also need to perform this attestation. If you're practicing exclusively in an inpatient hospital setting, you must indicate that on your CAQH application. This information is used to determine whether full credentialing is required.

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

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

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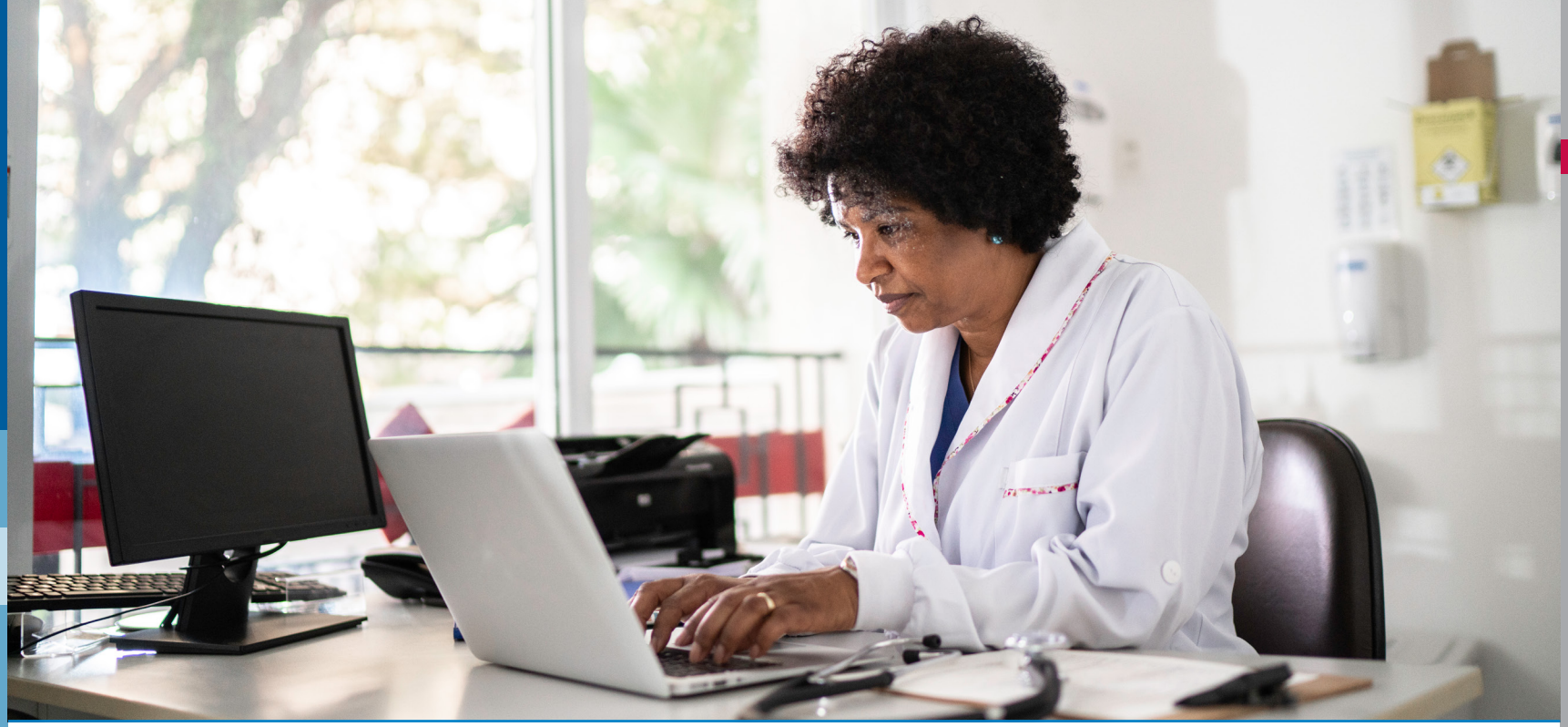


Register now for 2024 virtual provider symposium sessions

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

Once you're logged in to the provider training site, open the event calendar to sign up for any of the sessions listed below. You can also quickly search for all the sessions with the keyword "symposium" and then look under the results for *Events*.

All Star Performance-HEDIS® / Star Rating 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 - 10 a.m. Eastern time
All Star Performance - HEDIS®/Star Rating Measure Overview	May 15	9 - 10 a.m. Eastern time
All Star Performance - HEDIS®/Star Rating Measure Overview	May 23	2 - 3 p.m. Eastern time
All Star Performance - HEDIS®/Star Rating Measure Overview	May 30	3 - 4 p.m. Eastern time

Continued on following page

Coding and Documentation Tips for 2024 and Beyond: 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. - noon Eastern time
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	May 16	3 - 4 p.m. Eastern time
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	May 21	9 - 10 a.m. Eastern time
Let's Talk Coding: Coding and Documentation Tips for 2024 and Beyond	June 6	11 a.m. - noon Eastern time

Provider training website access

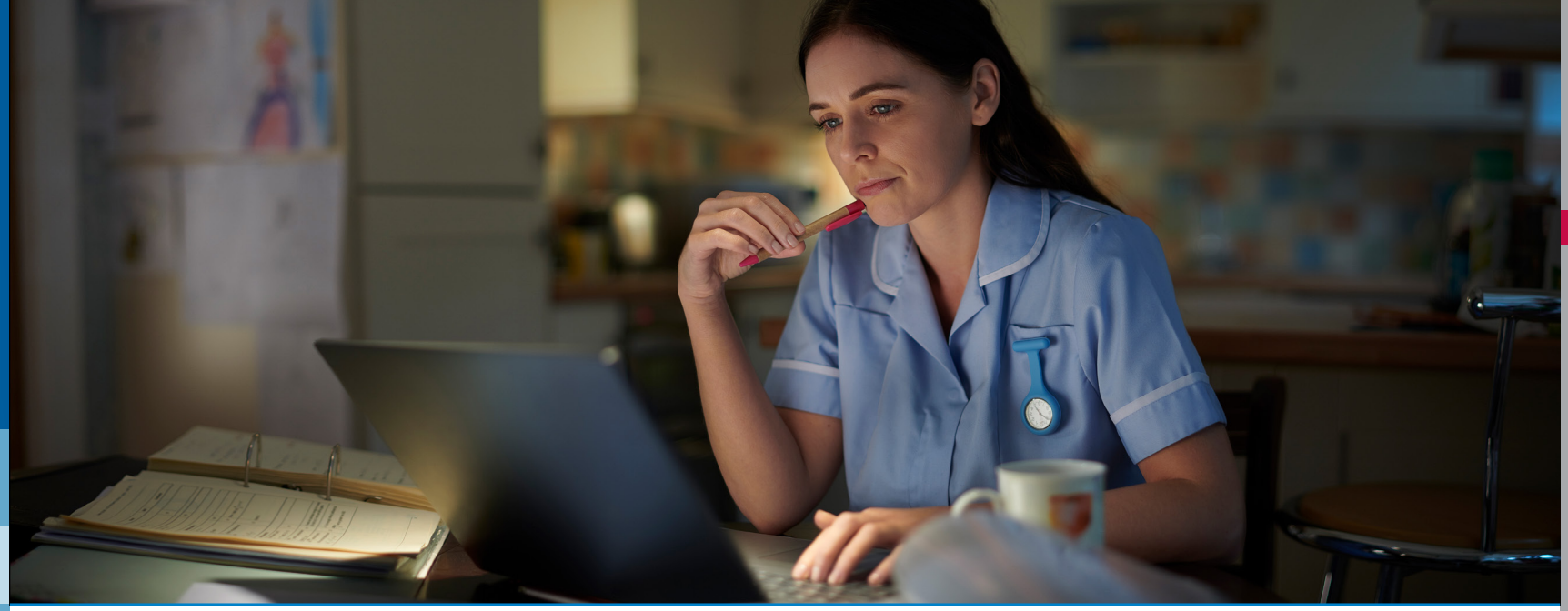
Provider portal users with an Availity® Essentials account can access the provider training website by logging in to availity.com, clicking on *Payer Space* in the top menu bar and then clicking on the BCBSM and BCN logo. Then click on the *Applications* tab, scroll down to the *Provider Training Site*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

You can also directly access the training website if you 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**.

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*.



Register now for Prior Authorization Programs with Carelon webinar

Provider office personnel responsible for obtaining prior authorizations are encouraged to register now for a webinar about the Blue Cross' utilization management program partnered with Carelon Medical Benefits Management (formerly AIM Specialty Health).

Carelon performs medical appropriateness reviews on for the following services: high-tech radiology, cardiology, radiation oncology, medical oncology and in-lab sleep studies. Prior authorization programs vary based on the member group contract and benefits.

This live session will present an educational overview of all the programs, as well as a demonstration of how to navigate the Carelon portal to submit, view and manage a prior authorization request. The presentation is followed by an Q&A period. You can register for this webinar on the provider training website.

Session	Date	Time
Prior Authorization Programs with Carelon	June 13	10 - 11 a.m. Eastern time

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*. Log in through **availity.com**.

You can also directly access the training website if you don't 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. Or quickly search for all the sessions with the keyword 'Carelon' and then look under the results for Events.

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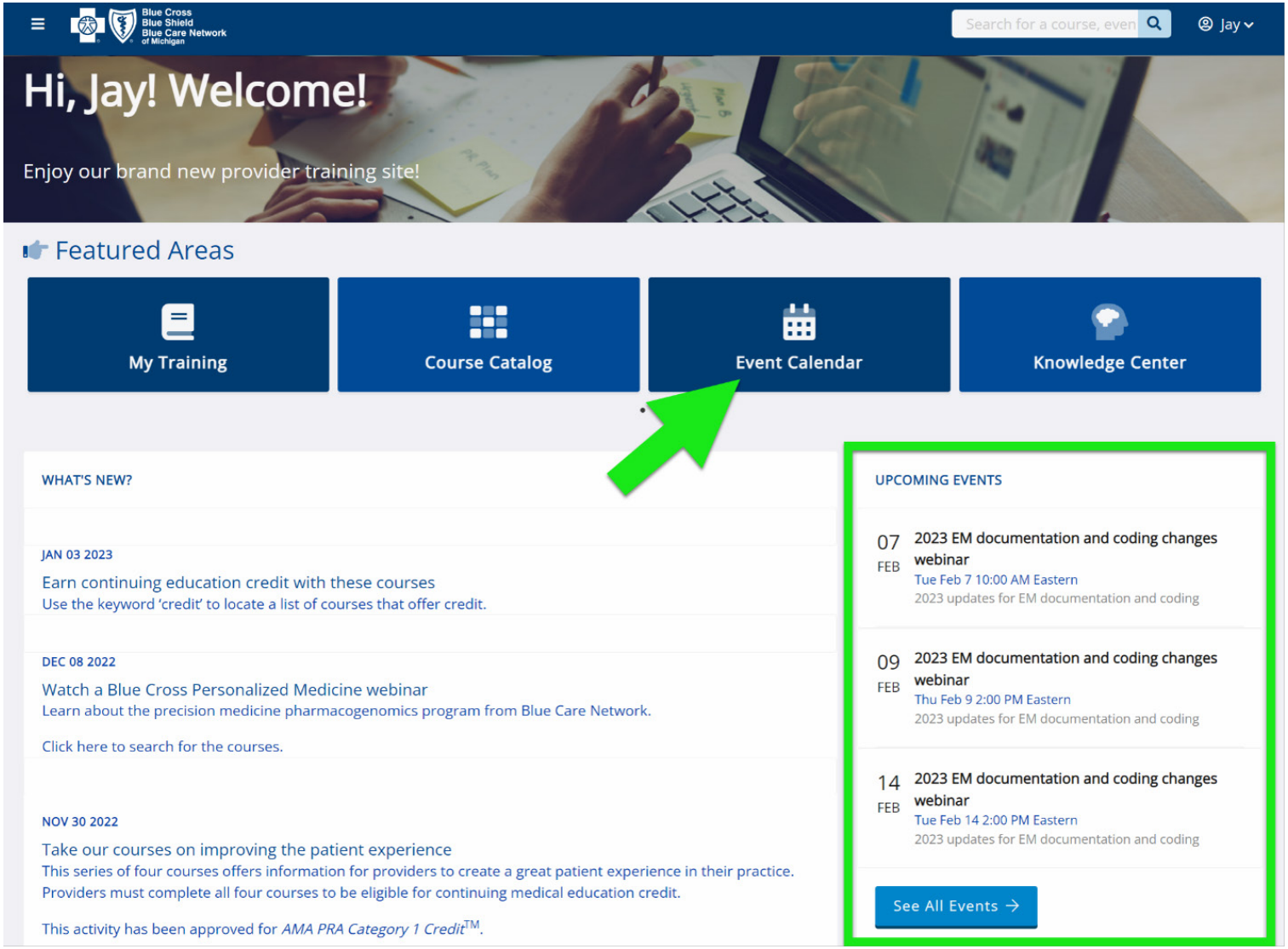
Network Operations



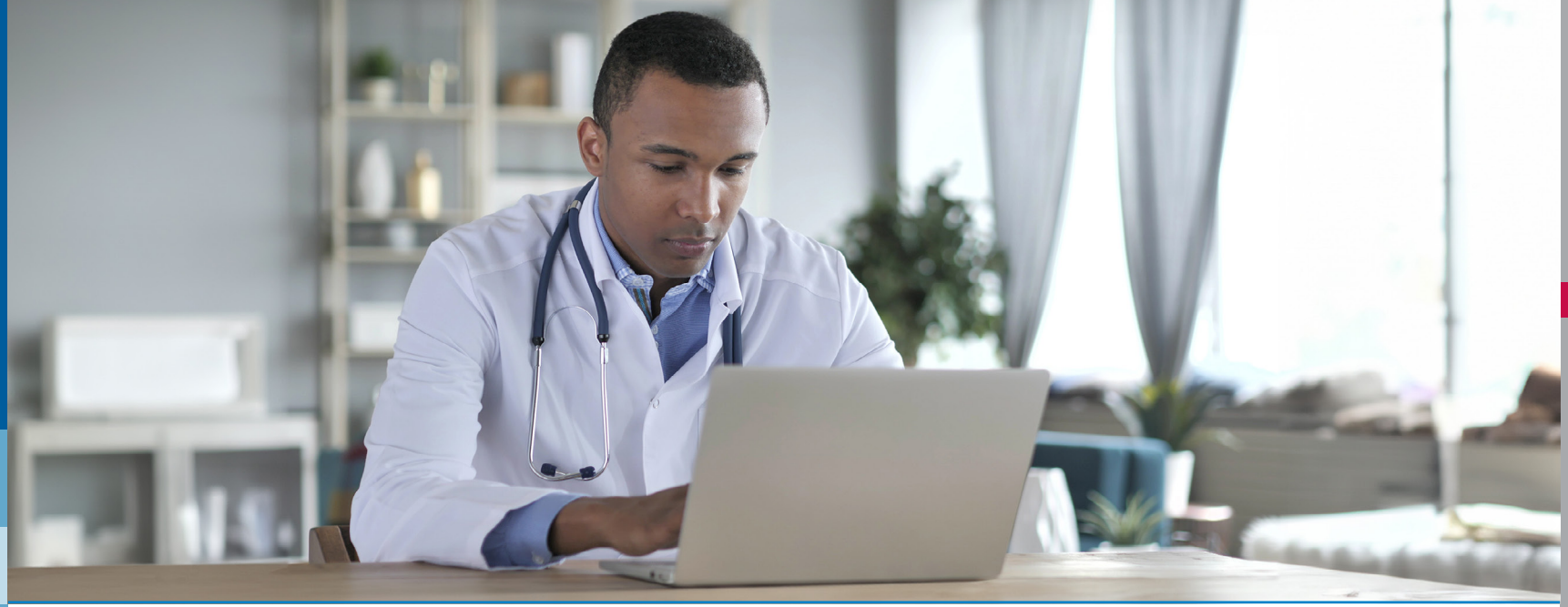
Questions?

- 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*.

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.

Network Operations



New on-demand training available: Check out our latest learning opportunities

Action item

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

We recently added the following learning opportunities:

- **Submitting appeals and peer-to-peer review requests in e-referral**

  The recording for the March 13, 2024 webinar for inpatient hospital providers is now available on the provider training website. You can also take the e-learning course that includes a simulation of the steps you take to submit requests. Search 'e-referral' to find these courses along with all other courses about the e-referral tool.

- **Provider portal mini modules**

  We have a series of short courses that can be completed in just a few minutes. **Click here for a quick introduction to our mini module concept**.

- **Carelon Medical Benefits Management overview**

  This course gives an overview of the prior authorization program administered by Carelon Medical Benefits Management. Search "Carelon" to quickly locate this course.

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 don't 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**.

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

Webinars for physicians, coders focus on risk adjustment, coding

We offer several webinars about documentation and coding of common challenging diagnoses. These live lunchtime educational sessions will also include an opportunity to ask questions.

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
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*. Log in through **availity.com**.

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. Or quickly search for all the sessions with the keyword 'lunchtime' and then look under the results for Events.

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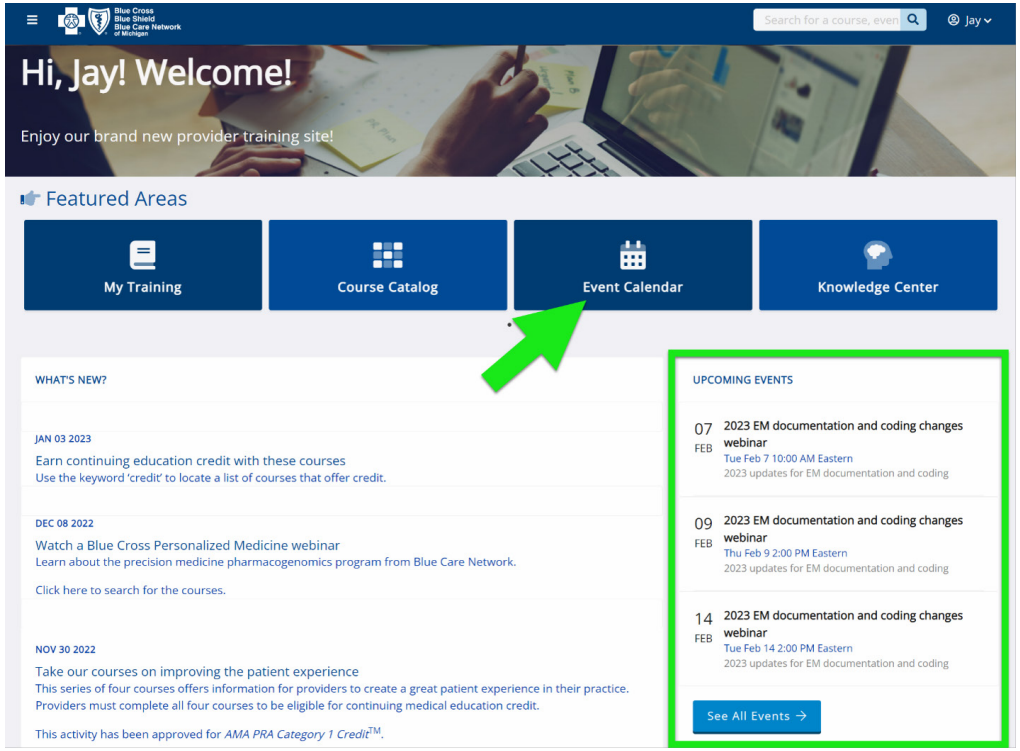
Network Operations



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.

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

- *New on-demand Patient Experience resources include tips for elder care, managing difficult patients and improving telehealth visits,* **Page 13**
- *Register now for our Behavioral Health Summit,* **Page 15**
- *Reminder: BCN and BCN Advantage professional claims must report the same POS code within the claim,* **Page 29**

BCN Advantage

We're no longer mailing some letters related to Medicare Advantage inpatient admissions

As of Jan. 17, 2024, we're no longer using the U.S. mail service to send some letters related to acute medical or surgical inpatient admissions for our Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members. The affected letters are those that indicate:

- We've bundled admissions for a member for billing purposes.
- We've denied an inpatient authorization request for a member.

We're now sending these letters to facilities by eFax or through the *Case Communication* field in the e-referral system.

When it's not possible to use eFax or the e-referral system, we'll send these letters though the U.S. mail.

As a reminder, we stopped using the U.S. mail to send approval letters for inpatient authorization requests for these members in 2023.

Quality Minute

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.

Medicare wellness visits

- Annual wellness visits, or AWVs, are the most critical visit for your Medicare Advantage members' quality of care and a component of contracts and incentive programs.
- AWVs can be scheduled anytime during the calendar year, regardless of the member's previous AWV. This means you do **not** have to wait 365 days from the previous AWV – every Medicare Plus Blue℠ and BCN Advantage℠ member is eligible for an AWV starting January 1 of the new year.
- AWVs can be completed and billed on the same day as an annual physical exam (*99385-87, *99395-97) or an evaluation & management service (*99202-215) if all components of both visits are met including all medical record documentation guidelines. Add modifier 25 to the physical or E & M code. Members should be informed that there may be cost associated with services billed in addition to the AWV.
- When an AWV is completed virtually with an E & M code, both video and audio are required.

Continued on following page

BCN Advantage

For more information:

- Refer to "Get ready for 2024 annual Medicare wellness visits" on page 10 of the **January-February issue of *BCN Provider News***.
- Refer to the Medicare Wellness Visits tip sheet. Here's how to find it:
  1. Log in to our provider portal (**availity.com**).
  2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
  3. Click the *Resources* tab.
  4. Click *Secure Provider Resources (Blue Cross and BCN)*.
  5. Click *Member Care* on the menu bar and then click *Clinical Quality* and *Tip Sheets*.

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

Successful phototherapy pilot program continues for eligible BCN members with psoriasis

In November 2022, Blue Care Network began a phototherapy pilot program to help address rising specialty drug costs. Select BCN members are eligible as part of their BCN health plan with pharmacy benefits to participate in the program at no additional cost if they have a diagnosis of mild to moderate psoriasis without psoriatic arthritis and haven't previously received a biologic medication.

Phototherapy, also referred to as "light therapy," is a safe and effective option recommended by the American Academy of Dermatology for patients with psoriasis who require more than topical medications or are seeking an additional option. Although the service is currently available to members, it has been challenging because it requires visits to a health care provider's location multiple times per week. This often leads to poor adherence and treatment discontinuation. Through this pilot program, members can treat their psoriasis in the comfort and privacy of their own home, at work, or at times that fit best with their schedule.

Feedback received for the first year of the pilot has been very positive. For participating members, self-reported satisfaction is averaging a 4.9 out of 5 rating, and a majority are achieving either clear skin after treatments or the ability to enter a maintenance phase to prevent future psoriasis flares.

The goal of the program is to reduce unnecessary progression to expensive biologic therapy. Make sure to regularly check in with your patient at clinic visits whether they are participating in any health care interventions, such as home light therapy, for consideration of their full treatment plan.

We're working with Zerigo Health

BCN has contracted with Zerigo Health to facilitate this program for network providers and plan members. Services provided by Zerigo Health include provider education, member enrollment, onboarding, consistent member communication and monitoring.

The service utilizes FDA cleared, narrow band ultraviolet B, or NB-UVB, phototherapy treatment that is self-administered at home through a smartphone-enabled handheld device. Secure cloud-based software automatically manages the dosing, frequency and duration of treatment, including adjustments based on the provider's prescribed protocol. Additionally, providers can opt in to receive their patients' progress reports to track adherence and satisfaction.

For more information on Zerigo Health, visit **zerigohealth.com**.

New on-demand Patient Experience resources include tips for elder care, managing difficult patients and improving telehealth visits

If you missed the live presentation of the three-part virtual workshop, "Improving Health Outcomes for Older Adults," you can watch each session **on demand**. This series was designed to help physicians and clinical staff navigate the complexities of discussing potentially sensitive issues with older patients and strategies to foster a more open dialog. This series also supports providers who adopt Blue Cross' Patient-Centered Medical Home, or **PCMH, capabilities 9.13 and 9.14** to screen seniors for fall risk, physical activity and bladder control, which are part of the At-Risk Communities value-based reimbursement.

- **Part 1 (45 minutes) – "Ensuring effective care through conversations"**

  Part 1 of the workshop focuses on ensuring effective care through conversations with patients about urinary incontinence, physical activity and fall risk. It also includes a brief background on the annual Health Outcomes Survey (HOS) conducted by the Centers for Medicare & Medicaid Services (CMS) to assess the health status of seniors over time.

- **Part 2 (45 minutes) – "Helping older patients maintain mental and physical health"**

  In Part 2, participants will hear about strategies to discuss mental health and physical health with older adults. The session also includes patient-centered planning to improve or maintain patients' health.

- **Part 3 (45 minutes) – "Overcoming barriers to sensitive conversations with patients"**

  Part 3 discusses the barriers and anxiety older patients have about broaching sensitive topics, such as memory problems and advanced care planning. Providers' apprehension to bringing up sensitive topics are also explored. The session includes tips to relieve patients' anxiety, ways to build trust and strategies providers can use to overcome their own anxieties about sensitive conversations.

Visit the **Upcoming Webinars** page of the **Blue Cross Patient Experience site** to view the live recordings or download the slides. CME credits are available for physicians. CEUs are also available for medical assistants.

New on-demand e-learning series and webinar now available

Many physician practices use telehealth visits to increase access for patients and provide greater flexibility in scheduling. Our new e-Learning series titled "Telehealth – Processes to maintain a great patient experience," helps practices ensure their virtual visits provide the same patient experience as in-office visits. Two modules are available:

- A module for clinicians focused on patient-centered care and communication tips (15 minutes)
- A module for office managers or leads with preparation and follow-up tips to ensure telehealth appointments are successful (15 minutes)

Visit the **on-demand page** of the Patient Experience site to access the training. CME credits are available for physicians and CEU's are available for medical assistants.

If you missed the live presentation of "Managing Challenging Patient Interactions" in March, check out the **on-demand page** of the Patient Experience site to view the webinar recording or download the slides. This webinar covers strategies for health care professionals to manage upset or frustrated patients or caregivers in office setting and tactics to prevent contentious situations. CME

Continued on following page

credits are available for physicians and CEU's are available for medical assistants.

More resources coming soon

Visit the **Upcoming Webinars** page of the Patient Experience site to register for our May webinar series focused on health equity for an aging population. This series highlights the barriers for hearing, vision, and cognitively impaired patients and the impact it has on their health care experience. We'll discuss strategies practices can implement to make care more inclusive for this vulnerable population of patients, along with additional resources for planning and staff training.

The Patient Experience team also offers in-office sessions to share best practices with staff and facilitate process improvement workshops. For more information on webinars, e-learning or to schedule a consultation with a Patient Experience consultant, email **PatientExperience@bcbsm.com**.

Medical policy updates

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

1. Go to **bcbsm.com/providers**.
2. Click *Resources* in the top navigation.
3. Click the *Search Medical Policies* button.

Recent updates to the medical policies include:

Covered services

- Aquablation (transurethral waterjet ablation) of the prostate
- Contrast-Enhanced Computed Tomography Angiography (CTA, CCTA, MDCT, MSCT) of the heart and/or coronary arteries
- Magnetic resonance imaging – targeted biopsy of the prostate
- Pressure gradient garments and support stockings
- Prostatic Artery Embolization (PAE) for Benign Prostatic Hypertrophy (BPH)
- Radioembolization for primary and metastatic tumors of the liver

Noncovered services

- Miscellaneous and genetic and molecular diagnostic tests
- Percutaneous and implantable tibial nerve stimulation

Established services

- Laser interstitial thermal therapy for neurological conditions
- Percutaneous Arteriovenous Fistula (pAVF)
- Suprachoroidal delivery of pharmacologic agents

Experimental/Investigational services

- Genetic testing multicancer early detection testing (e.g., Galleri)

Medical Policy Updates

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

- *Practice caution with requests for patient information,* **Page 1**
- *Register now for 2024 virtual provider symposium sessions,* **Page 4**
- *Register now for our Behavioral Health Summit,* **Page 15**
- *Quality Minute - Medicare wellness visits,* **Page 10**

Register now for our Behavioral Health Summit

Professional behavioral health providers and billers are invited to our upcoming Behavioral Health Summit. Attendees can interact with Provider Engagement & Transformation consultants, receive tailored presentations from various behavioral health-specific departments and network with peers and industry leaders. The summit will be held in person on Thursday, May 9 and Thursday, June 6, and virtually Thursday, Aug. 8.

Session date/time	Time	Registration
Thursday, May 9 ***RSVP by May 2***	1 - 3 p.m. Eastern time	**Register here** Lyon Meadows Conference Center Conference Room A 53200 Grand River Ave. New Hudson, MI 48165
Thursday, June 6 ***RSVP by May 30***	9 - 11 a.m. Eastern time	**Register here** Lyon Meadows Conference Center Conference Room A 53200 Grand River Ave. New Hudson, MI 48165
Thursday, Aug. 8 **(virtual only)**	Noon - 1:30 p.m. Eastern time	**Register here**

For more information about the summit, contact **providerengagement@bcbsm.com**.

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

- *Practice caution with requests for patient information,* **Page 1**
- *New on-demand training available: Check out our latest learning opportunities,* **Page 7**

Pharmacy News

Omvoh to have a site-of-care requirement for most commercial members starting May 1

We're adding a site-of-care requirement for Omvoh™ SC and IV (mirikizumab-mrkz), HCPCS code J3590, which is covered under the medical benefit, for dates of service on or after May 1, 2024. The new requirement applies to 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 Omvoh 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 Omvoh before May 1, 2024, will be able to continue receiving the drug in their current location until their existing authorization expires. If those members 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, the prior authorization and site-of-care requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under members' 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**.

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 at **ereferrals.bcbsm.com**:

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

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

NovoLogix is an independent company that provides an online prescription drug prior authorization tool for Blue Cross Blue Shield of Michigan and Blue Care Network.

Pemfexy step therapy requirements started in April

Members must try and fail two other pemetrexed drugs before we'll approve prior authorization requests for Pemfexy® (pemetrexed), HCPCS code J9304, for dates of service on or after April 26, 2024.

Members must try and fail two of the following drugs:

- Alimta® (pemetrexed), HCPCS code J9305
- Pemrydi® RTU (pemetrexed), HCPCS code J9324
- Pemetrexed (generic, various brands), HCPCS codes J9294, J9296, J9297, J9314, J9322, J9323

These drugs are covered under the members' medical benefits, not their pharmacy benefits.

All of the drugs listed above continue to require prior authorization through Carelon Medical Benefits Management, as specified in the pertinent drug lists, which are linked below. We'll update these lists to reflect the new step therapy requirement prior to the effective date.

Members affected by this change

This new requirement applies to:

- 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**. This includes members who have UAW Retiree Medical Benefits Trust non-Medicare plans.

    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

More about the prior authorization requirements

For a full list of requirements related to drugs covered under the medical benefit, see the following 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**

Prior authorization isn't a guarantee of payment. Health care providers 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.

BCN Provider News
Feedback

Blue Cross and BCN covers additional vaccines

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

Vaccine	Common name and abbreviation	Effective date
Penbraya™	Meningococcal serogroups A, B, C, W, Y vaccine (MenACWY-TT/ MenB-FHbp)	Jan. 1, 2024

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

Vaccines that have an age requirement

Vaccine	Common name and abbreviation	Age Requirement
Gardasil 9®	Human papillomavirus vaccine (HPV)	9 to 45 years old
Influenza virus	Influenza vaccine (Flu)	• Under 9: 2 vaccines per 180 days • 9 and older: 1 vaccine per 180 days
Prevnar 13®	Pneumococcal 13 - valent conjugate vaccine	65 and older

Vaccines that have no age requirement

Vaccine	Common name and abbreviation
• Dengvaxia®	Dengue vaccine (DEN4CYD)
• Daptacel® • Infanrix®	Diphtheria, tetanus, and acellular pertussis vaccine (DTaP)
Diphtheria and tetanus toxoids	Diphtheria, tetanus vaccine (DT)
• Kinrix® • Quadracel®	DTap and inactivated poliovirus vaccine (DTaP-IPV)
• Pediarix®	DTaP, hepatitis B, and inactivated poliovirus vaccine (DTaP-HepB-IPV)
• Vaxelis®	DTaP, inactivated poliovirus, Haemophilus influenzae type b, and hepatitis B vaccine (DTaP-IPV-Hib-HepB)

• ActHIB® • Hiberix® • PedvaxHIB®	Haemophilus influenzae type b vaccine (Hib)
• Havrix® • Vaqta®	Hepatitis A (HepA)
• Engerix-B® • Heplisav-B® • PreHevbrio™ • Recombivax HB®	Hepatitis B (HepB)
Twinrix®	Hepatitis A & B (HepA-HEPB)
• M-M-R II® • Priorix®	Measles, mumps, rubella vaccine (MMR)

Continued on following page

Vaccines that have no age requirement

Vaccine	Common name and abbreviation
ProQuad®	Measles, mumps, rubella and varicella vaccine (MMRV)
Menveo®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-CRM)
Menactra®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-D)
MenQuadfi®	Meningococcal serogroups A, C, W, Y vaccine (MenACWY-TT)
Penbraya™	Meningococcal serogroups A, B, C, W, Y vaccine (MenACWY-TT/ MenB-FHbp)
Bexsero®	Meningococcal serogroup B vaccine (MenB-4C)
Trumenba®	Meningococcal serogroup B vaccine (MenB-FHbp)
Vaxneuvance™	Pneumococcal 15-valent conjugate vaccine (PCV15)
Prevnar 20™	Pneumococcal 20-valent conjugate vaccine (PCV20)
Pneumovax 23®	Pneumococcal 23-valent polysaccharide vaccine (PPSV23)
IPOL®	Poliovirus (IPV)
• Arexvy™ • Abrysvo™ • Beyfortus™	Respiratory syncytial virus (RSV)
Rotarix®	Rotavirus vaccine (RV1)
RotaTeq®	Rotavirus vaccine (RV5)
• Tdvax® • Tenivac®	Tetanus and diphtheria vaccine (Td)
• Adacel® • Boostrix®	Tetanus, diphtheria and acellular pertussis vaccine (Tdap).
Varivax®	Varicella vaccine (VAR) (chickenpox)
Shingrix®	Zoster vaccine (RZV) (Shingles)

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

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

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

Additional preferred products for Soliris, Ultomiris now required for most commercial members

For dates of service on or after April 1, 2024, step therapy requirements changed for Soliris® (eculizumab), HCPCS code J1300, and Ultomiris® (ravulizumab), HCPCS code J1303.

Preferred products for Soliris and Ultomiris	
Before April 1, 2024	**On or after April 1, 2024**
Members must try and fail: • Vyvgart®	Members must try and fail **both**: • Rystiggo® • Either Vyvgart or Vyvgart Hytrulo

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

We've updated the **Blue Cross and BCN utilization management medical drug list** to reflect the new preferred drugs.

The drugs discussed above continue to require prior authorization through the NovoLogix® online tool.

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.

Additional information

For more information about medical benefit drugs, see the following pages on **ereferrals.bcbsm.com**:

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

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

Pharmacy News

Starting June 1, Blue Cross will no longer cover Sajazir injection

Starting June 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer cover Sajazir™ injection as a pharmacy benefit. Instead, we'll cover generic icatibant acetate subcutaneous injection. Sajazir is a medication commonly used to treat acute attacks of hereditary angioedema.

Both Sajazir and icatibant acetate subcutaneous injection are generic icatibant acetate products for brand name Firazyr® and are FDA-approved; however, Sajazir is more expensive than other available generic products. It also requires limited distribution through LeMed Specialty Pharmacy©, a nonpreferred specialty pharmacy, whereas the other generic products are available through specialty pharmacies. Our preferred specialty pharmacy is AllianceRx Walgreens Pharmacy.

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

We'll notify affected members of these changes and encourage them to talk with you to address any concerns and get a new prescription, if needed.

If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803.

We've changed how we manage Entyvio SC, Omvoh SC

On March 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network changed how we manage the following drugs for our Medicare Plus Blue℠ and BCN Advantage℠ members:

- Entyvio® SC (vedolizumab), HCPCS code J3590
- Omvoh™ SC (mirikizumab-mrkz), HCPCS code J3590

Note: This change doesn't affect Entyvio IV, HCPCS code J3380, or Omvoh IV, HCPCS code J3590, which will continue to be managed as part of members' Part B medical benefits. These drugs continue to require prior authorization through the NovoLogix® web tool.

What changed on March 1

Beginning March 1, Medicare Plus Blue and BCN Advantage members who previously received Entyvio SC or Omvoh SC under their Part B medical benefit are required to continue their treatments under their Part D pharmacy benefits.

We made this change because these therapies can be safely and conveniently self-administered in the home; the Centers for Medicare & Medicaid Services, or CMS, has added these drugs to the **Self-Administered Drug Exclusion List: (SAD List)**.

As a result:

- These drugs are no longer covered when administered by a doctor or other health care professional under the Part B medical benefit.
- Entyvio SC and Omvoh SC aren't included in our Medicare Advantage Part D formularies, but providers can request prior authorization for them as exceptions. (See the "How to submit prior authorization requests for Entyvio SC and Omvoh SC" section below.)
- Your patients can obtain these medications at pharmacies that dispense specialty drugs. They can also obtain these drugs from AllianceRx Walgreens Pharmacy through mail order or pickup at a Walgreens retail pharmacy.
- For members who don't have Part D pharmacy benefits through Blue Cross or BCN, providers need to work with the pharmacy vendor that provides each member's Part D coverage.

How to submit prior authorization requests for Entyvio SC and Omvoh SC

For members who have Part D pharmacy benefits through Medicare Plus Blue or BCN Advantage, providers need to submit prior authorization requests for Entyvio SC and Omvoh SC as follows:

- **Electronically**

  Through CoverMyMeds® or another free ePA tool, such as Surescripts® or ExpressPAth®. See **Save time and submit your prior authorization requests electronically for pharmacy benefit drugs** for more information.

- **By phone**

  Call 1-800-437-3803 and follow the prompts for medications billed through the pharmacy benefit.

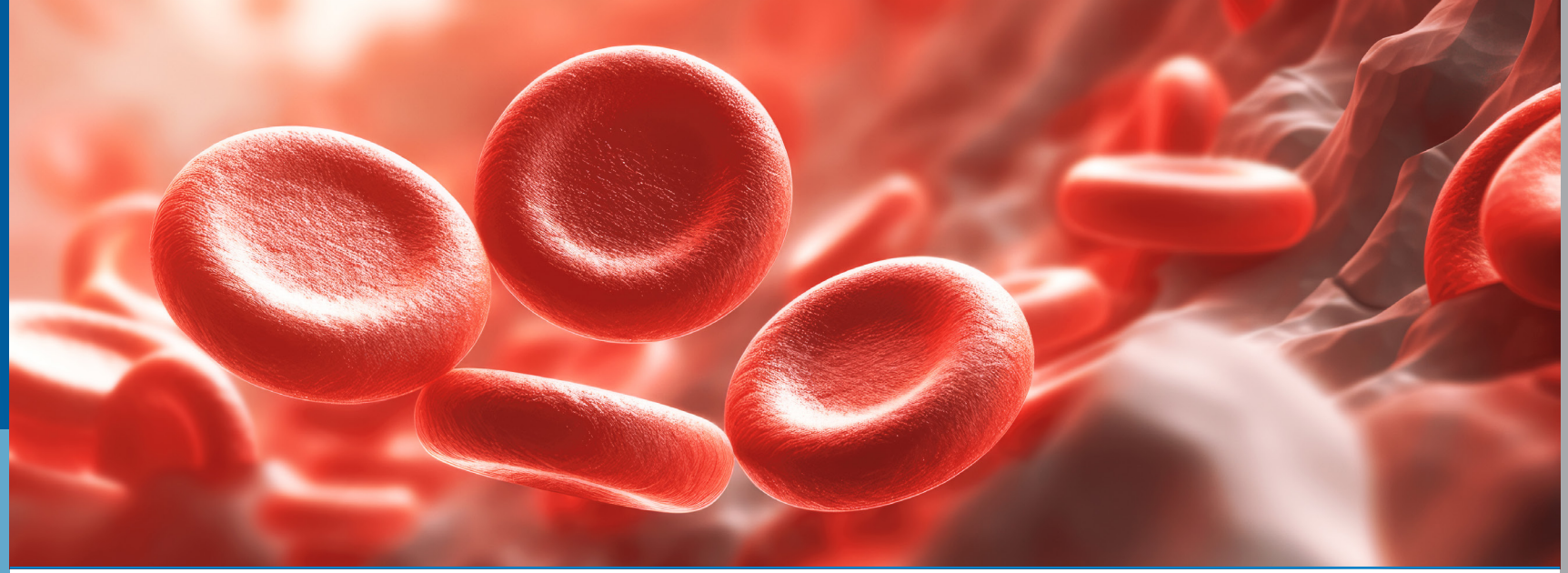
- **By fax:**
  - For Medicare Plus Blue requests, fax to 1-866-601-4428.
  - For BCN Advantage requests, fax to 1-800-459-8027.

List of requirements

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

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

Pharmacy News



Preferred product for Zynteglo for most commercial members started in April

For dates of service on or after April 19, 2024, we added a step therapy requirement for Zynteglo™ (betibeglogene autotemcel), HCPCS code J3590.

Preferred product for Zynteglo	
Before April 19, 2024	**On or after April 19, 2024**
There isn't a preferred product.	Members must try and fail Casgevy™.

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

We've updated the **Blue Cross and BCN utilization management medical drug list** to reflect the preferred drug.

The drugs discussed above continue to require prior authorization through the NovoLogix® online tool.

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.

Additional information

For more information about medical benefit drugs, see the following pages on **ereferrals.bcbsm.com**:

- **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.

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 January, February and March 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.

Changes in requirements

- **For Blue Cross commercial and BCN commercial members**

  We added prior authorization requirements, site-of-care requirements or both, as follows:

HCPCS code	Brand name	Generic name	Requirement	
			Prior authorization	Site of care
J1599	Alyglo™	Immune globulin intravenous, human-stwk 10%	✓	✓
J3590*	Amtagvi™	Lifileucel	✓	
J3590*	Avzivi®	Bevacizumab-tnjn	✓	
J3590*	Ryzneuta®	Efbemalenograstim alfa-vuxw	✓	

- **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
J3590	Casgevy™	Exagamglogene autotemcel	1/2/2024
J3590	Lyfgenia™	Lovotibeglogene autotemcel	1/2/2024
J3490	Omisirge®	Omidubicel-onlv	2/1/2024
J3590	Bimzelx®	Bimekizumab-bkzx	2/12/2024
J3590	Cosentyx® IV	Secukinumab	2/12/2024
J3590	Omvoh™ IV	Mirikizumab-mrkz	2/12/2024
J3590	Pombiliti™	Cipaglucosidase alfa-atga	2/12/2024
J3490	Rivfloza™	Nedosiran	2/12/2024
J3490	Zilbrysq®	Zilucoplan	2/12/2024
J3590	Zymfentra™ SC	Infliximab-dyyb	2/12/2024
J3590	Adzynma	ADAMTS13,recombinant-krhn	3/1/2024
J3490	Wainua™	Eplontersen	3/1/2024

Continued on following page

Pharmacy News

Code changes

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

New HCPCS code	Brand name	Generic name
J0217	Lamzede®	Velmanase alfa
J1304	Qalsody®	Tofersen
J1412	Roctavian™	Valoctocogene roxaparvovec-rvox
J1413	Elevidys	Delandistrogene moxeparvovec-rokl
J2508	Elfabrio®	Pegunigalsidase alfa-iwxj
J3401	Vyjuvek®	Beremagene geperpavec-svdt
J9333	Rystiggo®	Rozanolixizumab-noli
J9334	Vyvgart® Hytrulo	Efgartigimod alfa and hyaluronidase-qvfc

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 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.

Udenyca Onbody now requires prior authorization for most commercial members

For dates of service on or after March 5, 2024, we added a prior authorization requirement 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:

- Udenyca® Onbody (pegfilgrastim-cbqv), HCPCS code Q5111

Note: This change applies to UAW Retiree Medical Benefits Trust (non-Medicare) members.

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.

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

Some Blue Cross commercial groups aren't subject to this requirement

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

Note: Blue Cross and Blue Shield Federal Employee Program® members 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 updated 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.

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

Quality Minute

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.

The importance of medication review with every patient at every visit!

- Remind patients to bring their medications to each visit, you can add this to your messaging for appointment reminders.
- Use a standard phrase, such as "I'm going to review your medications." This will help with patient recall if they receive a CAHPS survey.
- The medical record must include the name of the person who reviewed the medications with the patient and the date of review.

Cost, side effects, and barriers to pharmacy pick up may impact medication adherence

- Remind patients to use their pharmacy benefit when paying for medications.
- A patient's pharmacy benefit is typically more cost effective than discount programs, especially for generic medications.
- Use of discount programs will not count toward pharmacy quality gaps such as medication adherence.
- 90-day mail order prescriptions are the gold standard to ensure patients adhere to their medication regimen.
- All active diagnoses should be submitted on claims annually to exclude members from quality measures for which their diagnoses make medications intolerable.

By following these simple tips, you'll greatly impact several Star measures!

For more information, refer to the **Medication Adherence Star measure tip sheet**. Here's how to find it:

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

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

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

- *Practice caution with requests for patient information,* **Page 1**
- *Successful phototherapy pilot program continues for eligible BCN members with psoriasis,* **Page 12**

Billing Bulletin

BCN urgent care providers recently moved to fee schedule reimbursement should update billing practices

Effective Jan. 1, 2024, Blue Care Network transitioned some providers currently receiving global/per diem reimbursement to the urgent care fee schedule. Providers impacted by this change received a letter and updated payment exhibit in October 2023.

As a reminder, the providers that received this communication should bill for individual services that occur during a visit. Per diem payments using S9083 are no longer payable.

This applies to covered services for BCN commercial and BCN Advantage℠ members.

To obtain a copy of the fee schedule, contact FeeSchedule@bcbsm.com.

Cotiviti to perform DRG cross-claim clinical reviews of BCN Advantage inpatient facility claims starting July 1

Beginning July 1, 2024, Cotiviti will perform diagnosis-related group, or DRG, cross-claim clinical reviews of BCN Advantage inpatient facility claims.

The reviews are based on the member's episode of care and won't initially require you to provide medical records. Here's more information you need to know:

- If you have claims selected for review without medical records, you'll receive a letter advising you of the results of the review.
- If Cotiviti identifies an opportunity for a change, you'll have the option to submit an appeal and provide the full medical records for consideration.

You'll be able to request first- and second-level appeals of the findings by the Physicians Review Organization.

If you have questions about this, contact Cotiviti Provider Relations at 1-770-379-2009 (Monday - Friday, 8 a.m. - 5 p.m. Eastern time).

Cotiviti is an independent company that provides auditing support services for Blue Cross Blue Shield of Michigan and Blue Care Network.

Reminder: BCN and BCN Advantage professional claims must report the same POS code within the claim

Action item

Use the same POS code for all services being billed on each claim.

We've received claims for professional services for BCN commercial and BCN Advantage members that contain different Place of Service codes; that is, POS codes within a claim that indicate different service locations.

We can't successfully process these claims. Remember—**you must use the same POS code for all services being billed on each claim**.

For proper adjudication of BCN commercial and BCN Advantage professional claims, follow these guidelines:

- For electronic 837 professional claims:
  - In Loop 2300 CLM05-1: Report the POS code that applies to all services billed on the claim.
  - In Loop 2400 SV105: Do not report a POS code at the service line level.
- For CMS-1500 paper claims:
  - Report the same POS code in box 24B for each service line.

BCN Advantage claims that contain different POS codes are automatically rejected and sent back to the provider. We will soon be updating our systems so that BCN commercial claims will also be automatically rejected. In either case, you'll have to submit a corrected claim.

Clinical editing billing tips

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

This issue's tips:

- Availity appeal submissions—Missing case number
- Correcting a claim to avoid sending an appeal

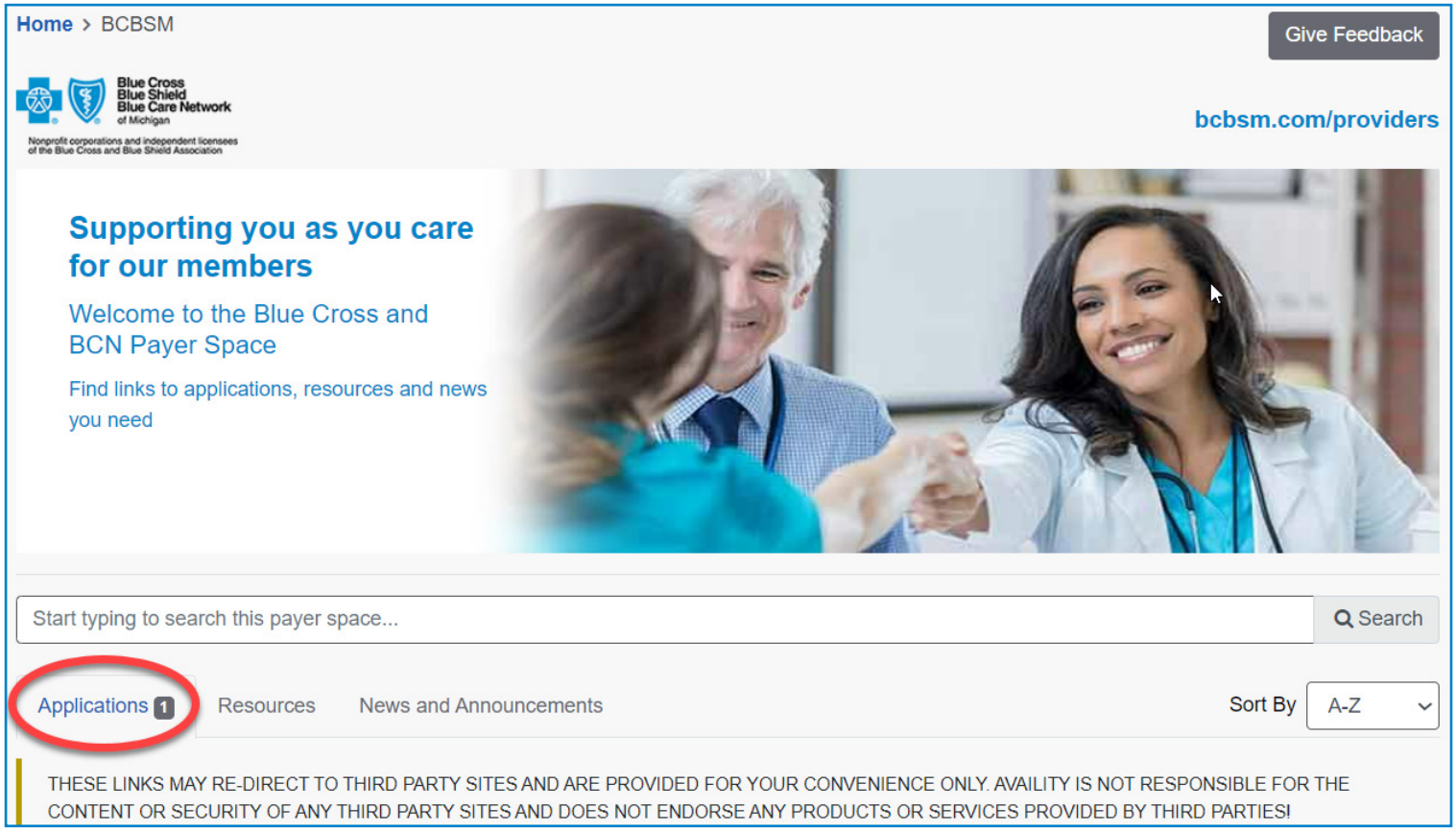
Clinical Editing Billing Tips

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

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

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

1. Logging 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. Click on the applicable tile in the *Applications* tab through which you submitted the authorization request.



Additional information available for providers

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

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

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.

Referral Roundup

Additional cardiology codes will require prior authorization through Carelon for commercial members, starting May 11

For dates of service on or after May 11, 2024, these additional cardiology codes will require prior authorization by Carelon Medical Benefits Management for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members:

- *0795T
- *0796T
- *0797T

Starting May 11, Carelon will use the Blue Cross and BCN medical policy titled *Leadless Cardiac Pacemakers* as the criteria for making determinations on prior authorization requests. To access this policy, open the **Medical Policy Router Search** page on **bcbsm.com**, enter the name of the policy in the *Policy/Topic Keyword* field and press *Enter*.

You'll be able to access Carelon's clinical criteria for these procedures, when available, on the **Current Cardiology Guidelines** page of the Carelon website.

Additional information

By May 11, we'll update **this document** to include the previously mentioned codes.

For more resources related to the cardiology procedures that require prior authorization, refer to these webpages at **ereferrals.bcbsm.com**:

- **Blue Cross Cardiology Services**
- **BCN Cardiology Services**

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

Changes to Gastric stimulation and Breast reconstruction questionnaires in e-referral system

On Feb. 25, 2024, we updated questionnaires in the e-referral system.

We also updated the corresponding preview questionnaires in 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.

Updated questionnaires

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

Questionnaire	Opens for	Updates
Gastric stimulation	• Medicare Plus Blue℠ • BCN commercial • BCN Advantage℠	Removed a question.
Breast reconstruction	• BCN commercial	Updated a question.

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.

Billing Bulletin

Prior authorization requirements are changing for musculoskeletal pain management and spinal procedure codes

For dates of service on or after June 3, 2024, we're adding prior authorization requirements for several pain management and spinal procedure codes that are managed through TurningPoint Healthcare Solutions LLC's Musculoskeletal Surgical Quality and Safety Management program.

The tables below outline the changes. In the tables:

- Some of the procedure codes represent specific procedures that have been separated out from more general procedures already managed by TurningPoint.
- Other procedure codes replaced codes that were retired by the American Medical Association.

Note: This change doesn't affect MESSA members. For additional information about which members are affected, see the Musculoskeletal Services and Pain Management Services pages on **ereferrals.bcbsm.com**.

Pain management procedure code

Procedure code	Change
*64625	Will require prior authorization for Medicare Plus Blue and BCN Advantage members. **Note**: This code will continue to require prior authorization through TurningPoint for Blue Care Network commercial members. It doesn't require prior authorization for Blue Cross Blue Shield of Michigan commercial members.

Continued on following page

Spinal procedure codes

Procedure code	Change
*0784T	Will require prior authorization for Blue Cross commercial, Medicare Plus Blue, BCN commercial and BCN Advantage members.
*0785T	
*0786T	
*0787T	
*0790T	Will require prior authorization for Medicare Plus Blue, BCN commercial and BCN Advantage members.
*22836	
*22837	
*22838	
*27278	Will require prior authorization for Medicare Plus Blue, BCN commercial and BCN Advantage members. **Note:** For dates of service before June 3, 2024, BCN Utilization Management manages prior authorizations for procedure code *27278 for BCN commercial and BCN Advantage members.

Additional information

We updated the document titled **Musculoskeletal procedure codes that require authorization by TurningPoint** to reflect these changes.

For more information about TurningPoint's Musculoskeletal Surgical Quality and Safety Management program, see the following pages on the **ereferrals.bcbsm.com** website:

- **Blue Cross Musculoskeletal Services**
- **Blue Cross Pain Management Services**
- **BCN Musculoskeletal Services**
- **BCN Pain Management Services**

TurningPoint Healthcare Solutions LLC is an independent company that manages prior authorizations for musculoskeletal surgical and other related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

Michigan acute inpatient facilities should submit peer-to-peer review requests and appeals through the e-referral system

Acute inpatient facilities in Michigan should use the e-referral system to submit peer-to-peer review requests and appeals related to prior authorization requests for inpatient acute care medical and surgical (non-behavioral health) admissions. Submitting these requests through the e-referral system involves completing questionnaires and attaching clinical documentation when applicable.

Submitting through the e-referral system offers a streamlined process that:

- Can help you meet submission deadlines and get faster responses
- Allows you to see initial prior authorization requests, peer-to-peer review requests and appeals in the same location

In addition, once you start using the e-referral system for these requests, you won't need to search through emails, wonder if a fax went through or call to confirm that a request has been received.

Here are some resources you can use to learn more about this:

- The document **How to request a peer-to-peer review with a Blue Cross or BCN medical director.** We've updated this document to include the details you'll need to know about using the e-referral system to submit these requests. In the table under the "Non-behavioral health services," look for the row labeled "Inpatient non-behavioral health non-elective admissions — in acute care hospitals for medical and surgical admissions."
- The training course "Submitting requests for appeals and peer-to-peer reviews in e-referral." For instructions on accessing the course on our Provider Training Site, refer to the article **New training course explains how to submit requests for appeals, peer-to-peer reviews in e-referral** in the March 2024 issue of *The Record*.
- The **e-referral User Guide**. Look in the section titled "Submit an inpatient authorization."

When the e-referral system is not available, you can:

- Submit peer-to-peer requests using the **Physician peer-to-peer request form (for non-behavioral health cases)**. Follow the instructions on the form.
- Submit appeals through traditional methods (fax, email or U.S. mail) as instructed in the denial letter.

You can't use the e-referral system to submit a peer-to-peer review request or appeal for prior authorization requests that:

- Were submitted prior to the member's admission
- Were administratively denied
- Are for inpatient behavioral health admissions
- Are for outpatient medical, surgical or behavioral health services
- Are for inpatient hospital clinical edit denials, pre-service denials, post-service audit overturns, post-claim bundling and claim denials
- Are for professional service authorization denials
- Are for denials made by a vendor

Non-Michigan facilities can't use the e-referral system to submit peer-to-peer review or appeal requests. They must continue to:

- Submit peer-to-peer requests using the **Physician peer-to-peer request form (for non-behavioral health cases)**.
- Submit appeals through traditional methods (fax, email or U.S. mail) as instructed in the denial letter.

Referral Roundup

BCN Provider *News*

Feedback

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

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JULY-AUGUST 2024

BCN Provider News

Be sure to use the correct provider taxonomy code to avoid payment delays

We use taxonomy codes to assist in the identification of a provider when they're using one NPI for several Blue Cross Blue Shield of Michigan provider IDs.

Blue Cross and Blue Care Network claims payment systems don't use every taxonomy code listed in the National Uniform Claim Committee, or NUCC, code set list. In the enrollment and credentialing process, if you submit a taxonomy code that we don't use, we'll change it to a higher-level taxonomy code. You must use the Blue Cross and BCN-assigned taxonomy code during the billing process to avoid possible payment delays. This applies to both Blue Cross and BCN commercial and Medicare Advantage plans.

Taxonomy codes designate your provider specialty. To find the provider taxonomy code you're required to use when submitting electronic claims to Blue Cross and BCN, refer to these documents located on **bcbsm.com**:

- **Taxonomy Code Mapping - Facility Providers**
- **Taxonomy Code Mapping - Professional Providers**

Here's are some examples:

- If you're submitting a claim for a family practice physician, you use taxonomy code 207Q00000X. This code is listed on the *Taxonomy Code Mapping - Professional Providers* document, so there is likely no change from what was submitted during the enrollment and credentialing process.
- If you're submitting a claim for a pediatric cardiologist, you will not find that specialty listed on the *Taxonomy Code Mapping - Professional Providers* document. As a result, you'll need to use the higher-level taxonomy code for pediatrics, 208000000X, even if that is not the code that was submitted during the enrollment and credentialing process.

Feedback | Subscribe

Inside this issue…

Network Operations

Daniel J. Loepp *Tricia A. Keith*

Tricia A. Keith to succeed Daniel J. Loepp as president and CEO of Blue Cross Blue Shield of Michigan

On May 15, 2024, Blue Cross Blue Shield of Michigan's Board of Directors appointed Tricia A. Keith to succeed Daniel J. Loepp as president and CEO following his retirement on January 1, 2025.

Mr. Loepp had many achievements during two decades of leadership at Blue Cross, including transforming the company from a large single-state health insurance plan to a diversified multi-company enterprise of national scale.

Ms. Keith, a Michigan native and lifelong resident, will become the company's first female chief executive. She has been with Blue Cross Blue Shield of Michigan since 2006, and currently serves as executive vice president, chief operating officer and president of Emerging Markets.

"She has the energy, experience, and innovative spirit our company needs as health care continues to change," Mr. Loepp said. "She is the right leader at the right time for Blue Cross Blue Shield of Michigan."

For more information, visit **MiBluesPerspectives.com**.

Here's how medical residents can join our network

Medical residents interested in joining our network can submit their Blue Cross Blue Shield of Michigan or Blue Care Network provider enrollment application up to 60 days before they complete their training.

It's important to apply within the required time frame. If medical residents apply more than 60 days before the completion of residency training, we'll deny the application and residents will have to reapply.

The **CAQH Provider Data Portal**, formally known as CAQH ProView, application must be completed to begin the credentialing process with Blue Cross and BCN. To keep CAQH information current, complete the re-attestation every 120 days and update the Authorize section. Visit the **CAQH Provider Data Portal** for more information on application requirements.

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How to protect yourself against health care fraud

Health care fraud is a serious crime that increases health care costs for everyone and can also present patient safety issues. Our Corporate and Financial Investigations Unit has put together the following tips to help protect you against health care fraud:

- **Verify requests for patient information**
  Provider offices may receive fraudulent requests for patient information, provider NPI numbers and provider signatures by standard mail, email or fax. Always verify requests before sending a response.
- **Verify patient ID**
  Ask for a picture ID to ensure that the person presenting the Blue Cross or BCN subscriber card is the owner of that card.
- **Use proper billing codes**
  Consult CPT and International Classification of Diseases code book and other resources to verify that the codes being used are appropriate and accurate.
- **Check patient history**
  To help prevent prescription drug fraud, ask patients if they are seeing or have obtained prescriptions from other doctors. Check Michigan Automated Prescription System (MAPS) reports.
- **Safeguard prescription pads**
  Prescription pads should not be left accessible to patients. Prescription fraud schemes are often perpetrated by use of stolen prescription pads or compromised e-prescribing passwords.
- **Make patient agreements**
  Enter into controlled substance or narcotics contracts with patients to express the importance of limiting medications usage as well as evaluating potential for addictive behaviors.

Action item

If you're suspicious of a request for information that you receive, contact our toll-free Fraud Hotline at **844-STOP-FWA** (844-786-7392) or send an email to **StopFraud@bcbsm.com**.

If you suspect a request may be fraudulent, don't respond to it!

When we conduct mass requests for medical records or patient information, we often notify you through a provider newsletter article or a provider alert. If you're suspicious of a request that you receive, you can contact our Fraud Hotline at **1-844-STOP-FWA** (1-844-786-7392) or send an email to **StopFraud@bcbsm.com**. We may ask you to share the request so we can check its legitimacy.

For more useful information, check out the Victimized Provider Project section of the Centers for Medicare & Medicaid website. The **Victimized Provider Project** helps keep providers from being held liable for overpayment for claims paid that are the result of identity theft.

By working together, we can help eliminate fraud, an effort that will improve patient safety and reduce costs.

Tips to help administrators keep patients' information secure

Unauthorized access to patients' protected health information is a very serious threat to all health care providers. In addition to personal health details, patient PHI often contains other valuable information such as Social Security Number, date of birth and account billable details. For these reasons, office administrators must do everything they can to minimize the risks associated with unauthorized access.

To help safeguard patient PHI and comply with federal law, office administrators are encouraged to incorporate the following steps as best practices:

- **Account management**
  Support a centralized tool for user account creation, modification, and termination.
  - Define, review, and update access permissions to align with job roles and responsibilities.
  - Provide clear instructions for employees to report any issues or concerns.
  - Provide a clear policy outlining employee access rights and privileges, such as, executing suitable member inquires.
- **Access review frequency**
  Initiate access reviews when employees change roles or departments; revoke access promptly.
  - Schedule quarterly or bi-annual audits of access levels to ensure compliance.
  - Update employee access and roles to align with current job functions.
- **Termination procedures**
  Set up procedures for promptly revoking access upon employee termination.
  - Coordinate with the Human Resources department to ensure access termination aligns with employee departure dates.
  - Conduct post-termination access audits to verify access removal.

For more useful tips, refer to the **Keep Office Information Secure** document on **ereferrals.bcbsm.com**.

Network Operations

New mini modules available to help you navigate the Blue Cross behavioral health provider portal

The provider training team would like to introduce two new mini modules that will help with some common issues our behavioral health providers sometimes experience within the Blue Cross behavioral health provider portal:

- *Blue Cross Behavioral Health Provider Portal Error Issue – Signing in*
- *Blue Cross Behavioral Health Provider Portal Error Issue – Authorization not found*

These take less than four minutes to complete and give tips on how you can resolve issues within the portal. Whether you are receiving an error at sign-on or when attempting to search an authorization, these modules can resolve issues to get you the outcome you are looking for. You can find these mini modules on the provider training site by searching "behavioral health" or "mini" in the search box on the upper right corner of the page.

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.

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.

If you need assistance navigating the provider training site, email **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.

New on-demand training available: Check out our latest learning path

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

Our newest learning path contains courses for the behavioral health community. This is our latest in the approach for helping providers and staff determine the right courses to take. We'll keep updating the courses as new ones are created that cover behavioral health topics. This will ensure you have the latest information that's easy to find in one spot.

The behavioral health learning path will feature a brand-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 and BCN. It addresses potential provider challenges, reviews current resources, walks through scenarios, and challenges the learner's knowledge along the way. You can also find upcoming courses in the learning path such as a mini-module on the Behavioral Health portal.

Professional providers and facilities should encourage those in the behavioral health field to view the new path. Simply open the Course Catalog on the provider training website and click on *Learning paths*.

Network Operations

BCN Provider *News*
Feedback

PCPs to select one PO with an affiliated MCG to support all Blue Cross and BCN business

Blue Cross Blue Shield of Michigan and Blue Care Network are asking primary care providers to align with one physician organization, and that PO's affiliated medical care group, to receive support for all Blue Cross and BCN lines of business in which the PCP chooses to participate. This includes Blue Cross and BCN commercial and Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠).

This alignment needs to occur before January 1, 2026, but PCPs are encouraged to consider their options and make any necessary changes now. Working with a Blue Cross PO and its related BCN MCG will maximize efficiency for Blue Cross and BCN reporting, incentives and value-based contracting. We expect this change to reduce the administrative burden on PCPs and result in more time for patient care.

What PCPs need to do

Review the **list of POs and their corresponding MCGs**.

- **If the PCP is already part of a PO and MCG that align**, there is no action needed. If you have any questions, contact your PO.
- **If the PCP is not already part of a PO or MCG**, review the list of POs and their corresponding MCGs and reach out to them to inquire about participation requirements, including the benefits and services they offer.
- **If the PCP is with one PO for Blue Cross contracts and an MCG that doesn't align to that same PO for BCN contracts**, determine which entity you will align with going forward. Talk to both entities to ensure you make an informed choice.
- **If the PCP is in the Upper Peninsula**, there is no need to align with a BCN MCG, as there is currently not a corresponding MCG to the Upper Peninsula Health Group PO.

Notes:

- A PCP can participate in the Blue Cross networks without aligning to a PO. However, we encourage PCPs to join a PO to maximize value-based reimbursement, incentive opportunities, and opportunities for a value-based contract.
- In some cases, a PCP may be able to participate in the BCN and BCN Advantage networks without aligning to a PO/MCG entity, but participation is limited based on the needs of the network. We encourage PCPs to join a PO/MCG entity to benefit from incentives, value-based opportunities and administrative support.

For more information

Here's where you can learn more:

- Read the article, **"Blue Cross and BCN align PCP contracting entities"** in the May-June 2024 issue of *Hospital and Physician Update*
- Contact your Blue Cross PO or BCN MCG
- Reach out to PO or MCG contacts in the **list of POs and their corresponding MCGs**

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

- *Register now for our virtual Behavioral Health Summit*, **Page 11**
- *AllianceRx Walgreens Pharmacy will become Walgreens Specialty Pharmacy on August 1*, **Page 13**

New webpage provides Medicare Advantage prior authorization clinical review criteria in one convenient location

Blue Cross Blue Shield of Michigan and Blue Care Network Medicare Advantage plans (Medicare Plus Blue℠ PPO, BCN Advantage℠ HMO, BCN Advantage℠ HMO-POS) require prior authorization for certain benefits.

Blue Cross and BCN recently launched the **Medicare Advantage Prior Authorization** webpage on **bcbsm.com** where you can quickly find clinical review criteria associated with services that require prior authorization. This new webpage puts the information you need in one convenient location.

Reminder

Before rendering services, make sure you check benefits, eligibility and medical policy coverage guidelines, using the self-service tools on our provider portal at **availity.com**.

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

Select Medicare Advantage members will receive Cologuard® test kit in June

Blue Cross Blue Shield of Michigan and Blue Care Network are working with Exact Sciences, an existing, credentialed colorectal cancer screening provider, to distribute in-home Cologuard test kits in June. The kits will go to select Medicare Plus Blue℠ PPO and BCN Advantage℠ members. Health care providers with patients who receive an advance notice letter about the kit should encourage them to take advantage of this convenient, no-cost screening.

Members who have a gap in care for colorectal cancer screening will receive a Cologuard screening kit. Once completed, members will be encouraged to discuss test results with their primary care providers.

Test result notification

	All results	Positive result
Blue Cross MA member	• Letter directing member to Exact Sciences MyChart to review results • Text message and email, if member provides contact information, notifying results are ready • Members can contact Exact Sciences Patient Support Line 24/7	• Up to three phone call attempts to notify member of positive result • If unable to reach member by phone, we'll mail a certified letter with the positive result attached
Primary care provider	• Mailed • Faxed, if fax number is provided • Provider offices can also receive results by contacting Exact Sciences at **1-844-870-8870**, view on the Epic Care portal or by requesting results at **https://www.cologuardhcp.com/contact-us**	

Cologuard by Exact Sciences is an independent company that provides colorectal testing services to Blue Cross Blue Shield of Michigan and Blue Care Network members.

Talk to Medicare Advantage members about how to maintain independence and confidence

To help our Medicare Plus Blue℠ and BCN Advantage℠ members remain independent and feel confident as they age, we've asked them to talk to their health care providers about the following issues:

- Fall risks and how to avoid them
- Physical activity and realistic exercise expectations
- Preventing urine leakage, for members who deal with incontinence
- Feeling good about their overall health and managing pain so they can do routine activities, for members who are experiencing a decline in health

We're encouraging our Medicare Advantage members to share their concerns with you like they would with a close friend. We're suggesting they write down their concerns and read from the list or hand it to you so you can start the discussion.

We also encourage you to discuss these issues with patients even if the patient doesn't initiate the conversation. Many patients don't ask questions about these topics because they forget or don't know what to ask, they're embarrassed or they assume they have to "live with it."

When you bring up these topics, it opens the door to a conversation that may not otherwise happen. It also helps your patients to know these are common issues and what types of questions they should ask going forward.

We appreciate your efforts to make members as comfortable as possible when discussing sensitive issues.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *Change coming to nonclinical, transitional care program through Home & Community Care,* **Page 9**
- *Use JW and JZ modifiers when billing Part B medical benefit drug claims,* **Page 14**
- *Elrexfio and Talvey to require prior authorization for most members starting June 20,* **Page 15**
- *Step therapy requirement to be added for VPRIV and Elelyso for Medicare Advantage members starting June 1,* **Page 16**
- *Pemfexy and Pemrydi RTU to have additional step therapy requirements for most members,* **Page 26**
- *Step therapy requirement added for botulinum toxins for Medicare Advantage members starting Aug. 5,* **Page 27**
- *Changes coming to prior authorization process for post-acute care services for Medicare Advantage members,* **Page 33**

Patient Care/ Quality

Change coming to nonclinical, transitional care program through Home & Community Care

Currently, the nonclinical, transitional care program through Home & Community Care (formerly known as naviHealth, Inc.) is available to Medicare Plus Blue℠ and BCN Advantage℠ members who are discharged to their homes or to certain post-acute care facilities in Michigan from acute inpatient facilities. This program aims to reduce avoidable inpatient readmissions.

On May 31, 2024, Home & Community Care will discontinue this 30-day program for members who are discharged to their homes. As a result, Home & Community Care navigation specialists won't contact members discharged after May 1. This will ensure all members engaged in the program complete it by May 31.

Starting June 1, 2024, the program will be available only to our Medicare Advantage members discharged to certain post-acute care facilities in Michigan. For more information about the program and to view the list of post-acute care facilities, see the document **Nonclinical, transitional care program for Medicare Advantage**.

We updated our communications, including the document linked above, to reflect this change.

Blue Cross Blue Shield of Michigan and Blue Care Network are working to develop a plan to ensure seamless care for members who are discharged to their homes and are at low risk for readmission.

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

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.

Kidney Health Evaluation for Patients with Diabetes (KED)

To help close the diabetes care HEDIS measure, follow these tips for a kidney health evaluation:

- For patients 18 to 85 years of age with diabetes, complete both an eGFR (blood) **and** uACR (urine) test.
- The uACR component can be satisfied by ordering a quantitative urine albumin test (*82043) **and** a urine creatinine test (*82570) less than four days apart **or** a urine albumin creatine ratio (uACR) lab test. There isn't a CPT code for uACR. This test is reported through LOINC codes.
- If your practice performs in-office testing, determine what kind of analyzer you use and the type of urine albumin test being performed. Some analyzers only measure semi-quantitative urine albumin, which are reported using different codes and will **not** close gaps.
- Chronic Kidney Disease is classified using both the eGFR and uACR to appropriately assign a stage. CKD can be diagnosed if there is evidence of decreased kidney function (eGFR), kidney damage (elevated uACR) or both for **at least three months**. It is important to use the appropriate ICD-10 code to classify CKD severity and avoid using CKD unspecified code, when possible.

For more information, refer to the ***Kidney Health Evaluation for Patients with Diabetes* tip sheet** or 2024 *Kidney Health Evaluation for Patients with Diabetes Network Performance Improvement* presentation. Here's how to find them.

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources* (*Blue Cross and BCN*).
5. Click *Member Care* on the menu bar and then click *Clinical Quality* and *Tip Sheets* for the tip sheet or *Clinical Quality Overview* for the presentation.

BCN Provider News
Feedback

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

- Analysis of human FIT-DNA (i.e., ColoGuard®) in stool samples as a technique for colorectal cancer screening
- Assisted reproductive techniques
- Genetic testing for Amyotrophic Lateral Sclerosis
- Genetic testing-noninvasive prenatal screening for fetal aneuploidies, microdeletions, single-gene disorders and twin zygosity using cell-free fetal DNA
- Germline and somatic biomarker testing (including liquid biopsy) for targeted treatment in prostate cancer (BRCA1/2, homologous recombination repair gene alterations)
- Obstructive sleep apnea - non-surgical treatment
- Obstructive sleep apnea and snoring - surgical treatment
- Prostate cancer early detection: Biomarkers prior to biopsy
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Telemonitoring-remote patient monitoring and remote therapeutic monitoring
- Vagus nerve stimulation

Noncovered services

- Computer-aided evaluation as an adjunct to magnetic resonance imaging for prostate cancer
- Digital health technologies therapeutic applications
- Microcurrent Electrical Neurostimulation (MENS)
- Remote Electrical Neuromodulation (REN) for migraines

Medical Policy Updates

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

Register now for our virtual Behavioral Health Summit

Professional behavioral health providers and billers are invited to our upcoming virtual Behavioral Health Summit. Attendees can interact with Provider Engagement & Transformation consultants, receive tailored presentations from various behavioral health-specific departments and network with peers and industry leaders. The summit will be held virtually on Thursday, Aug. 8.

Session date/time	Time	Registration
Thursday, Aug. 8 (virtual only)	Noon - 2:00 p.m. Eastern time	**Register here**

For more information about the summit, contact **providerengagement@bcbsm.com**.

Screening for and managing diabetes and high cholesterol risk from antipsychotic medications

Antipsychotic medications are essential for managing various psychiatric disorders, but they can also lead to metabolic side effects such as diabetes and high cholesterol. Screening for and managing these conditions is crucial to ensure the overall health and well-being of patients on antipsychotic therapy.

Patients on antipsychotic medications should undergo regular screening for diabetes due to the increased risk associated with these drugs. Fasting blood glucose levels, HbA1c tests and oral glucose tolerance tests are recommended screening methods. Early detection allows for timely intervention and management to prevent complications.

For patients diagnosed with diabetes while on antipsychotic therapy, a multidisciplinary approach is essential. Collaborating with endocrinologists, dietitians and mental health professionals can help optimize diabetes management while addressing the psychiatric needs of the patient. Lifestyle modifications, medication adjustments and close monitoring are key components of diabetes management in this population.

Elevated cholesterol levels are also a common side effect of antipsychotic medications and can increase the risk of cardiovascular disease. Regular lipid profile screenings are recommended to monitor cholesterol levels. Lifestyle modifications, such as dietary changes and exercise, should be encouraged to help manage high cholesterol.

In cases where patients develop high cholesterol while on antipsychotic therapy, a comprehensive approach is necessary. Statin therapy may be considered in consultation with a cardiologist to lower cholesterol levels and reduce cardiovascular risk. Monitoring lipid profiles regularly is crucial to assess the effectiveness of treatment.

Screening for and managing diabetes and high cholesterol in patients taking antipsychotic medications is vital to prevent long-term complications and improve overall health outcomes. Healthcare providers should be vigilant in monitoring metabolic parameters in this population to provide comprehensive care that addresses both psychiatric and physical health needs.

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Behavioral Health

Guidelines for using the *Autism diagnostic evaluation results form*

Members can obtain an autism evaluation using one of the methods described in the document ***Obtaining an autism diagnostic evaluation and finding treatment***.

If you choose to record the results of the autism evaluation on the ***Autism diagnostic evaluation results form***, follow these guidelines:

- Use only the current version of the form, which is dated Jan. 1, 2024, or later. Older versions include fax numbers that should no longer be used.
- Record the diagnosis on the form, even if it isn't an autism diagnosis.
- Don't fax the form. Give it to the member or to the member's parent or guardian along with the components of the evaluation. The member should give the form and the evaluation components to the treating practitioner.

  Note: We're still receiving the older forms from approved autism evaluation centers. Faxing these forms to Blue Cross and BCN — instead of giving them to the member or to the member's parent or guardian — can delay the members getting the treatment they need.
- If you're the treating provider, submit the form and the evaluation components to Blue Cross Behavioral Health℠ when you request prior authorization.

We've updated the document ***Blue Cross Behavioral Health: Frequently asked questions for providers*** to include this information. Providers can access that document on our **ereferrals.bcbsm.com** website, on these pages:

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

Prior authorization no longer required for autism-related PT, OT, ST and physical medicine services for BCN commercial members

Autism-related physical, occupational and speech therapy by therapists and physical medicine services by athletic trainers and chiropractors no longer require prior authorization for BCN commercial members 19 and older. We've updated our processes to reflect this change.

Please don't submit prior authorization requests to eviCore healthcare for these services when they're related to an autism diagnosis.

We updated our communications to reflect this change.

eviCore healthcare 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.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *New mini modules available to help you navigate the Blue Cross behavioral health provider portal,* **Page 5**
- *New on-demand training available: Check out our latest learning path,* **Page 5**

Pharmacy News

AllianceRx Walgreens Pharmacy will become Walgreens Specialty Pharmacy on August 1

Effective August 1, 2024, AllianceRx Walgreens Pharmacy, a provider of specialty pharmacy services, will become Walgreens Specialty Pharmacy.

Walgreens Specialty Pharmacy will continue to provide Blue Cross Blue Shield of Michigan, Blue Care Network commercial and Medicare Advantage members with specialty medications used to treat chronic, complex or rare conditions.

Members are being notified of the name change through their prescription orders, which started in May. They can continue to call **1-866-515-1355** should they have questions about their specialty medications.

Send prescriptions to Walgreens Specialty Pharmacy by:

- Phone: **1-866-515-1355**
- Fax: **1-866-515-1356**
- Electronically/E-prescribing name: Walgreens Specialty Pharmacy – MICHIGAN

Use modifiers JW and JZ when billing Part B medical benefit drug claims

To receive timely and appropriate payment of Part B claims for Medicare Plus Blue℠ and BCN Advantage℠ members, health care providers, facilities and suppliers must include the JW or JZ modifier when billing for single-dose vials or other single-use packages of Part B drugs. This doesn't apply to multi-use vials or other multi-use packages.

For claims submitted on or after Oct. 1, 2023, the Centers for Medicare & Medicaid Services requires health plans to return claims without processing them when claim lines don't include the appropriate modifiers. The claims must then be resubmitted with the appropriate modifiers. This applies to all providers, facilities and suppliers who buy and bill separately payable single-container drugs under Medicare Part B.

Here's how to use these HCPCS Level II modifiers:

- The **JW modifier** is required when reporting the amount of drug that is discarded and is eligible for payment under the discarded drug policy.

  Example: A single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the member and five units discarded. The 95-unit dose is billed on line one, while the discarded five units are billed on line two using the JW modifier. Both line items are processed for payment. Providers must record the discarded amounts of drugs and biologicals in the member's medical record.
- The **JZ modifier** is used to attest that no amount of drug was discarded.

Here's what you need to include on these claims:

Type of claim	What to do
Waste-related claim (JW modifier)	Submit two complete claim lines. Include the following information. **Line 1:** • HCPCS code for the drug administered • Number of units administered to the member (in the example above, you'd enter 95 units) • Calculated price for only the amount administered to the member **Important:** Don't include a modifier on line 1. **Line 2:** • HCPCS code for the drug that was wasted • JW modifier to indicate waste • Number of units wasted (in the example above, you'd enter 5 units) • Calculated price for only the amount of drug wasted
Claim with no waste — Entire amount of drug is administered (JZ modifier)	Submit one claim line. Include the following information: • HCPCS code for the drug administered • JZ modifier to indicate there was no waste • Number of units administered to the member • Calculated price for the amount of drug administered

For additional information, see the **CMS Billing and Coding: JW and JZ Modifier Billing Guidelines** page on **cms.gov**.

Elrexfio, Talvey require prior authorization for most members, starting June 20

For dates of service on or after June 20, 2024, the following drugs require prior authorization through the Oncology Value Management program:

- Elrexfio™ (elranatamab-bcmm), HCPCS code J1323
- Talvey™ (talquetamab-tgvs), HCPCS code J3055

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

Prior authorization requirements apply when these drugs are administered in outpatient settings for:

- Blue Cross Blue Shield of Michigan commercial:
  - All fully insured members (group and individual).
  - Members who have coverage through **self-funded groups that have opted in to the 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

How to submit prior authorization requests

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

- Go through the Carelon provider portal, 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 Provider Portal* 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 provider portal at **providerportal.com**.
- Call the Carelon Contact Center at **1-844-377-1278**.

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**

As a reminder, prior 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

Step therapy requirement to be added for VPRIV, Elelyso for Medicare Advantage members, starting June 1

For dates of service on or after June 1, 2024, health care providers must show that Medicare Plus Blue℠ and BCN Advantage℠ members tried and failed Cerezyme® (imiglucerase) when requesting prior authorization for the following drugs:

- VPRIV® (velaglucerase alfa), HCPCS code J3385
- Elelyso® (taliglucerase alfa), HCPCS code J3060

Cerezyme is Blue Cross Blue Shield of Michigan and Blue Care Network's preferred enzyme replacement therapy for Gaucher disease.

These drugs are covered under members' medical benefits, not their pharmacy benefits.

Providers should submit prior authorization requests for VPRIV and Elelyso through the NovoLogix® online tool.

As a reminder, Cerezyme doesn't require prior authorization for dates of service on or after Jan. 1, 2024.

When prior authorization is required

VPRIV and Elelyso require prior authorization when they are administered by a provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

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

Submit prior authorization requests through NovoLogix

To access NovoLogix, log in to our provider portal at **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.

If you need to request access to our provider portal, follow the instructions on the ***Register for web tools*** page on **bcbsm.com**.

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**.

NovoLogix is an independent company that provides an online prescription drug prior authorization tool for Blue Cross Blue Shield of Michigan and Blue Care Network.

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.

Columvi, Daxxify, Qalsody to require prior authorization for URMBT members with Blue Cross non-Medicare plans

For dates of service on or after July 1, 2024, the drugs listed below will require prior authorization for UAW Retiree Medical Benefits Trust members with Blue Cross Blue Shield of Michigan non Medicare plans.

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

See the table below for:

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

Brand name	Generic name	HCPCS code	Submit requests through
Columvi™	Glofitamab-gxbm	J9286	Carleon Medical Benefits Management provider portal
Daxxify®	Daxibotulinum toxinA-lanm	J0589	NovoLogix® online tool
Qalsody™	Tofersen	J1304	NovoLogix online tool

The prior authorization requirement applies apply only when these drugs are administered in an outpatient setting.

Note: The requirement doesn'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, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. On the Applications tab, click the tile for the Carelon provider portal or the appropriate NovoLogix tool.

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

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

More about requirements for medical benefit drugs

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

- **Medical oncology prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
- **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare Members**

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

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

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

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

Cinryze, Elfabrio, Evkeeza to have site-of-care requirement for most commercial members, starting July 1

For dates of service on or after July 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 covered under the medical benefit:

- Cinryze® (c-1 esterase), HCPCS code J0598
- Elfabrio® (pegunigalsidase alfaiwxj), HCPCS code J2508
- Evkeeza® (evinacumab-dgnb), HCPCS code J1305

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

Additional information or documentation may be required for requests to administer Cinryze, Elfabrio and Evkeeza in an outpatient hospital setting.

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

Members who start courses of treatment with Cinryze, Elfabrio or Evkeeza before July 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**
- **BCN Medical Benefit Drugs**

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

NovoLogix is an independent company that provides an online prescription drug prior authorization tool for Blue Cross Blue Shield of Michigan and Blue Care Network.

Vyjuvek has a site-of-care requirement for most commercial members

For dates of service on or after April 4, 2024, we added a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Vyjuvek™ (beremagene geperpavec-svdt), HCPCS code J3401

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 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

Additional information or documentation may be required for requests to administer Vyjuvek 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 started courses of treatment with Vyjuvek before April 4, 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've updated this list to reflect the Vyjuvek change.

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

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

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

Pharmacy News

Amtagvi has additional requirements for most commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network updated the medical policy for Amtagvi™ (lifileucel). The requirements in the updated medical policy apply for most Blue Cross and BCN commercial members for dates of service on or after May 28, 2024.

The following additional requirements must be met for treatment with Amtagvi to be considered medically necessary:

- Members haven't received prior treatment:
  - With any tumor infiltrating lymphocyte, or TIL, therapy despite indication.
  - With any other genetically modified TIL therapy and aren't being considered for treatment with any other genetically modified TIL therapy.
- The treatment must be administered at a certified TIL treatment center.

You can see the full list of requirements in the updated medical policy. To view the policy, go to the **Medical Policy Router Search** page, enter the name of the drug in the *Policy/Topic Keyword* field and press *Enter*.

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

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

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

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

Additional information

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

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

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

Cosentyx IV to have a site-of-care requirement for most commercial members starting July 1

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

- Cosentyx® IV (secukinumab), HCPCS code J3590

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

Additional information or documentation may be required for requests to administer Cosentyx IV in an outpatient hospital setting.

As a reminder, this drug already requires prior authorization; providers can submit prior authorization requests using NovoLogix. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who start courses of treatment with Cosentyx IV before July 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, 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**
- **BCN Medical Benefit Drugs**

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

Omvoh SC and IV have a step therapy requirement for most commercial members

For dates of service on or after June 3, 2024, members must try and fail four preferred products before we'll approve prior authorization requests for Omvoh™ SC and IV (mirikizumab-mrkz), HCPCS code J3590.

The four preferred products for Omvoh SC and IV are:

Brand name (generic name)	Benefit under which drug may be covered
Humira® (adalimumab)	Pharmacy
Simponi® (golimumab)	Pharmacy
Stelara® SC (ustekinumab)	Pharmacy and medical
Xeljanz/XR® (tofacitinib) **or** Rinvoq® (upadacitinib)	Pharmacy

For the preferred products, providers need to comply with any requirements, such as prior authorization, which applies under the applicable benefit.

For Omvoh SC and IV:

- The step therapy requirement applies to most Blue Cross Shield of Michigan and Blue Care Network group and individual commercial members.
- Providers should continue to submit prior authorization requests through the NovoLogix® online tool.

We'll update the **Blue Cross and BCN utilization management medical drug list** to reflect the preferred drugs.

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

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

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

Additional information

For more information about medical benefit drugs, see the following pages on **ereferrals.bcbsm.com**:

- **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.

Spevigo SC has requirements for most commercial members

For dates of service on or after April 25, 2024, we added 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:

- Spevigo® SC (spesolimab-sbzo), HCPCS code J1747

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

Note: If you need to request access to our provider portal, see the ***Register for web tools*** 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 Spevigo in an outpatient hospital setting.

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

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

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've updated this list to reflect the Spevigo SC changes.

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.

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.

Additional drugs to have a site-of-care requirement for some commercial members starting Aug. 1

For dates of service on or after Aug. 1, 2024, the following medical benefit drugs will have a site-of-care requirement for some Blue Cross Blue Shield of Michigan and all Blue Care Network group and individual commercial members:

Brand name	Generic name	HCPCS code
Darzalex Faspro™	daratumumab and hyaluronidase-fihj	J9144
Herceptin Hylecta™	trastuzumab and hyaluronidase-oysk	J9356
Kanjinti™	trastuzumab-anns	Q5117
Mvasi™	bevacizumab-awwb	Q5107
Ogivri®	trastuzumab-dkst	Q5114
Perjeta®	pertuzumab	J9306
Phesgo™	pertuzumab, trastuzumab and hyaluronidase–zzxf	J9316
Rituxan Hycela®	rituximab-hyaluronidase human	J9311

When the site-of-care requirement goes into effect, these drugs may be covered only when administered at the following sites of care:

- Doctor's or other health care provider's office
- The member's home, administered by a home infusion therapy provider
- Ambulatory infusion center

These drugs already require prior authorization through the Oncology Value Management program, administered by Carelon Medical Benefits Management. The new site-of-care requirement is in addition to any current prior authorization requirements.

Commercial members affected by this change

- Blue Cross commercial:
  - All fully insured members (group and individual), with the exception of MESSA members.
  - 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 in to this program, the site-of-care requirement doesn't apply.)

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

How the site-of-care requirement will be phased in

The site-of-care requirement will apply as follows for infusions involving the drugs listed above:

- **For courses of therapy starting on or after Aug. 1, 2024:** These infusions may not be covered at outpatient hospital facilities.
- **For courses of therapy that start before and continue beyond Aug. 1, 2024:** These infusions may not be covered at outpatient hospital facilities starting Nov. 1, 2024. To continue treatment at an outpatient hospital facility, you'll need to submit a prior authorization request to Carelon for approval prior to Nov. 1.

Please see Site-of-care requirement continued on Page 25

Site-of-care requirement, *continued from Page 24*

What to do for members who currently receive these drugs

For Blue Cross and BCN commercial members who currently receive these drugs at an outpatient hospital facility:

- Locate an in-network home infusion therapy provider or ambulatory infusion center at which the member may be able to continue their infusion therapy.
- Discuss with the member how to facilitate receiving their infusions at an allowed site of care.

For Blue Cross and BCN commercial members who currently receive these drugs at a provider's office, at home or in an ambulatory infusion center, no action is required.

How we'll help

For members who need to transition to a new infusion location, we'll work with you and the member to facilitate the transition. We'll notify members and encourage them to talk to you before changing their infusion location. We'll also let them know that the change of location doesn't affect the treatment you're providing.

List of requirements

- To view requirements for drugs covered under the medical benefit, refer to the ***Blue Cross and BCN utilization management medical drug list*** for Blue Cross and BCN commercial members. We'll update this list prior to the effective date on Aug. 1
- You can access this list and other information about submitting prior authorization requests to Carelon at **ereferrals.bcbsm.com** on the following pages:
  - **Blue Cross Medical Benefit Drugs**
  - **BCN Medical Benefit Drugs**

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

Pemfexy and Pemrydi RTU to have additional step therapy requirements for most members

Members must try and fail two other pemetrexed drugs before we'll approve prior authorization requests for Pemfexy® or Pemrydi RTU®. For the details, refer to this table:

Nonpreferred product	Step therapy requirement	For dates of service on or after
Pemfexy (pemetrexed), HCPCS code J9304)	Must try and fail at least two of the preferred products listed below.	April 26, 2024
Pemrydi RTU (pemetrexed), HCPCS code J9324	Must try and fail at least two of the preferred products listed below.	Aug. 1, 2024

The preferred products are:

- Alimta® (pemetrexed), HCPCS code J9305
- Pemetrexed (generic, various brands), HCPCS codes J9294, J9296, J9297, J9314, J9322 and J9323
- Pemrydi RTU, for dates of service from April 26 through July 31, 2024

  Note: For dates of service on or after Aug. 1, Pemrydi RTU will no longer be a preferred product, as indicated in the table above.

These drugs are covered under members' medical benefits, not their pharmacy benefits.

All of the drugs listed above continue to require prior authorization through the Carelon provider portal, as specified in the pertinent drug lists linked below. We'll update these lists to reflect the new step therapy requirement prior to the effective date.

Members affected by this change

This requirement applies to the following members:

- Blue Cross Blue Shield of Michigan commercial
  - All fully insured members (group and individual).
  - Members who have coverage through **self-funded groups that have opted in to the Carelon medical oncology program**. This includes members who have UAW Retiree Medical Benefits Trust non-Medicare plans.

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

More about the prior authorization requirements

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

- Blue Cross commercial and BCN commercial
  - **Oncology Value Management 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
  - **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

As a reminder, prior 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.

Step therapy requirement added for botulinum toxins for Medicare Advantage members starting Aug. 5

For dates of service on or after Aug. 5, 2024, providers will have to show that our Medicare Plus Blue℠ and BCN Advantage℠ members tried and failed Xeomin® (incobotulinum toxin A), HCPCS code J0588, when requesting prior authorization for the following drugs:

- Botox® (onabotulinumtoxin A), HCPCS code J0585
- Dysport® (abobotulinumtoxin A), HCPCS code J0586
- Daxxify® (daxibotulinumtoxin A), HCPCS code J0589
- Myobloc® (rimabotulinum toxin B), HCPCS code J0587

Xeomin is the preferred botulinum toxin product for Medicare Plus Blue and BCN Advantage members.

Here's other important information:

- Step therapy with Xeomin won't be required for requests to treat chronic migraines or urinary conditions such as overactive bladder.
- Xeomin won't require prior authorization for dates of service on or after June 1, 2024. For dates of service before June 1, submit prior authorization requests through the NovoLogix® online tool.
- Submit prior authorization requests for Botox, Dysport, Myobloc and Daxxify through NovoLogix.

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

When prior authorization is required

These drugs require prior authorization, as applicable, when they're administered by a health care provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

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

Submit prior authorization requests through NovoLogix

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

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

Quality MINUTE

Blue Cross Blue Shield Blue Care Network of Michigan

BCN Provider News
Feedback

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.

Statins

- Once patients demonstrate they can tolerate statin therapy, encourage them to obtain 90-day supplies through their pharmacy or mail-order pharmacy. Members can sign up for OptumRx home delivery online at **optumrx.com** or by calling 1-855-810-0007.
- Statin quality measures are dependent on pharmacy claims and patients must fill their prescriptions using their pharmacy benefit to count toward gap closure. Discount programs, VA benefits, cash claims and medication samples **don't** count toward quality measures.
- To exclude patients who can't tolerate statin medications, a claim **must** be submitted **annually** using the appropriate diagnosis code. Diagnoses that exclude members from statin measures can be found in the statin tip sheets.

For more information, refer to the ***Statin Therapy for Patients with Cardiovascular Disease (SPC)***, ***Statin Use in Persons with Diabetes (SUPD)*** and *Statin Therapy for Patients with Diabetes (SPD)* tip sheets. Here's how to find them.

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

OptumRx is an independent company that processes prescription claims and prior authorizations for services provided under the pharmacy benefit for Blue Cross Blue Shield of Michigan and Blue Care Network 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.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *Tips to help administrators keep patients' information secure,* **Page 4**
- *Changes coming for select weight loss drugs for some commercial members,* **Page 37**

JULY-AUGUST 2024

Billing Bulletin

BCN Provider *News*

Feedback

We're granting a 90-day extension to the time limit for commercial claim submission

Recognizing that many providers were affected by the recent Change Healthcare incident, Blue Cross Blue Shield of Michigan and Blue Care Network are granting a 90 day extension to the claim submission time limits for Blue Cross and BCN commercial claims. This includes primary original claims submitted on or after Feb. 22, 2024.

The 90-day extension ends Sept. 30, 2024. For all primary original claims submitted on or after Oct. 1, 2024, existing participation or affiliation agreement submission deadlines will apply.

The 90-day claim submission extension applies only to claims for Blue Cross commercial and BCN commercial. It doesn't apply to Medicare Advantage (Medicare Plus Blue℠ or BCN Advantage℠), Medicare Supplement or other secondary claims.

All audit rights and other plan rules still apply.

Thank you for your continued care of our members who are your patients.

Blue Cross, BCN to begin reimbursing E/M when billed with preventive service

Blue Cross Blue Shield of Michigan and Blue Care Network will begin reimbursing for evaluation and management, or E/M, services at 50% of the allowed amount when billed on the same day as a preventive service (see list). The preventive service will pay in full. This is a change from Blue Cross and BCN's current policy that only pays for the preventive service.

When two services are done on the same day, the modifier 25 must be billed with the E/M code or it won't be paid.

This reimbursement change will begin with dates of service beginning June 1, 2024. If a denial occurs while the claim system is being updated, resubmit your claim after the update is complete. The update is expected to be completed in late June. Do not submit an appeal for dates of service after June 1.

E&M Codes reimbursed at 50%

- *99202 – 99205
- *99211 – 99215
- *99341 – 99345
- *99347 – 99350

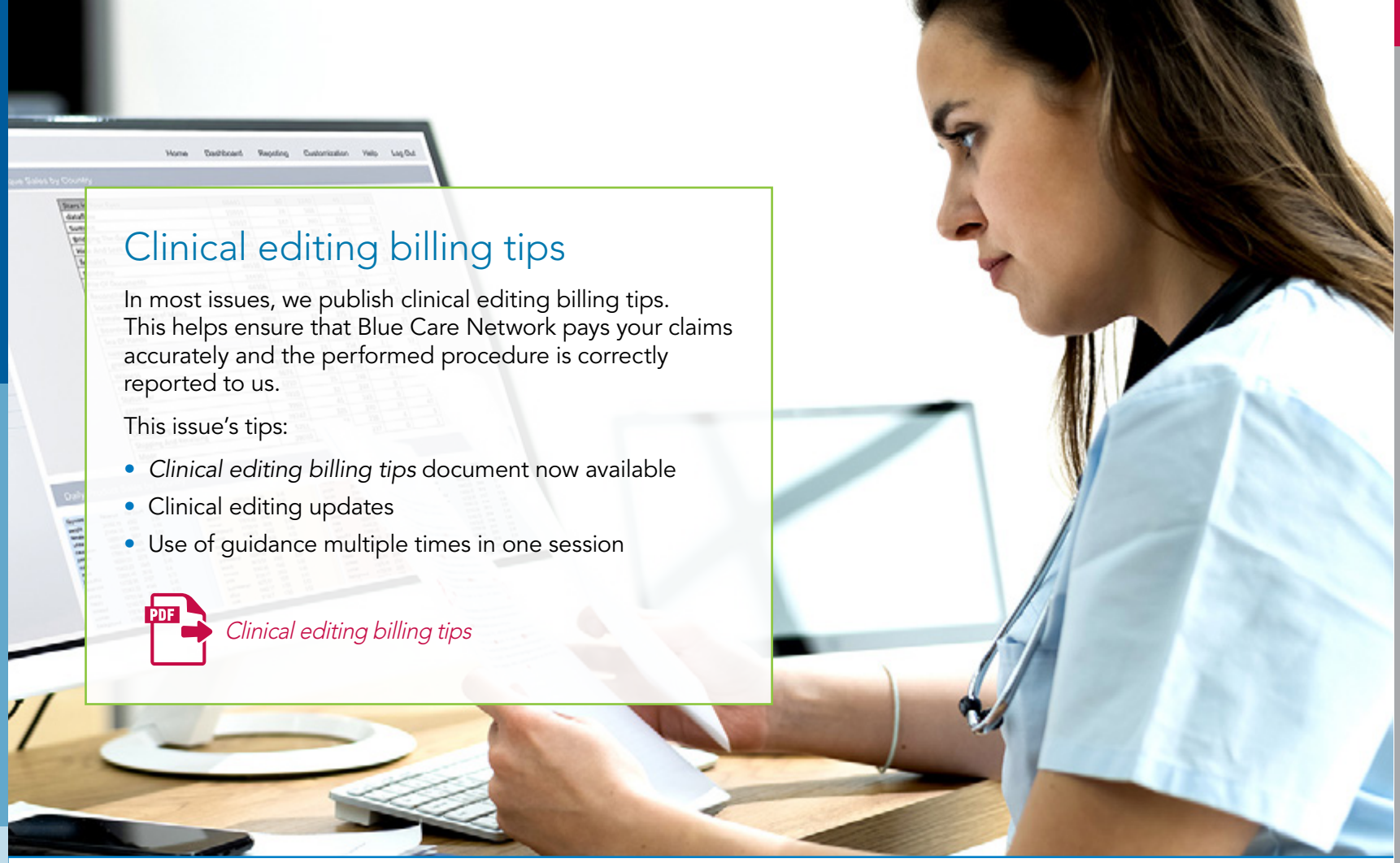
Preventive Codes

- *99381 – 99387
- *99391 – 99397
- *99401 – 99404
- *99406 – 99409
- *99411 – 99412
- S0610
- S0612-S0613

Billing Bulletin

BCN Provider *News*

Feedback



Clinical editing billing tips

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

This issue's tips:

- *Clinical editing billing tips* document now available
- Clinical editing updates
- Use of guidance multiple times in one session

Clinical editing billing tips

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

TurningPoint opens peer-to-peer reviews to advanced practice providers for musculoskeletal and pain management procedures

TurningPoint Healthcare Solutions LLC is now scheduling peer-to-peer reviews with advanced practice providers, or APPs (physician assistants and nurse practitioners). The APP peer-to-peer review process is available for participating orthopedic, pain management and spinal surgical practices that are contracted with Blue Cross Blue Shield of Michigan, Blue Care Network or both.

TurningPoint made this change to enable APPs to support physicians in the peer-to-peer review process. APPs can participate in peer-to-peer reviews related to routine prior authorization denials specific to coding, medical policy and documentation requirements for knee, ankle, shoulder, hip, elbow, wrist, spine and pain management procedures.

Reviews will be conducted by providers of the same provider type. For example, if the requesting provider is a physician assistant, the review discussion will be scheduled with a physician assistant at TurningPoint.

If you have questions about which cases are eligible for APP peer-to-peer reviews, contact the TurningPoint Provider Relations team at **providersupport@turningpoint-healthcare.com**.

We recently posted the following TurningPoint documents to the *Musculoskeletal Services* and *Pain Management Services* pages on **ereferrals.bcbsm.com**. These documents are also available through the TurningPoint Provider Portal.

- **TurningPoint Peer to Peer Quick Reference Guide**
- **TurningPoint Advance Practice Practitioner (APP) Peer-to-Peer Process**

We updated the ***Musculoskeletal procedure authorizations: Frequently asked questions for providers*** document to reflect this change.

Note: Provider offices will continue to have access to specialty-matched physician-to-physician peer-to-peer reviews.

For more information about TurningPoint's Musculoskeletal Surgical Quality and Safety Management program, including information about which groups and members participate in the program, see the following pages on **ereferrals.bcbsm.com**:

- **Blue Cross Musculoskeletal Services**
- **Blue Cross Pain Management Services**
- **BCN Musculoskeletal Services**
- **BCN Pain Management Services**

TurningPoint Healthcare Solutions LLC is an independent company provides care review services for Blue Cross Blue Shield of Michigan and Blue Care Network.

Save time by submitting only required information about acute inpatient medical, surgical admissions

When health care providers submit a prior authorization request for an acute inpatient medical and surgical admission, they can save time by submitting only the information that's required for the request.

Refer to the table below for more information.

Type of information to submit or type of request	How to submit
Names of members admitted to the hospital	Use the e-referral system to submit a prior authorization request for each admission.
Names of members discharged from the hospital	For each member discharged: • If the case is still open in the e-referral system, enter the discharge date for the member. • If the case has closed because the authorized days have elapsed, you don't need to do anything.
Clinical information	• If the prior authorization request was approved in the e referral system, don't submit additional clinical information. • If the member needs additional days, use the e-referral system to request those days and attach the clinical information to the request.
Information on sick newborns **Note:** The authorization request is separate from the delivery.	Information about sick newborns **must** be faxed because those members can't be found in the e-referral system. Complete the **Acute inpatient hospital assessment form** and fax it to the correct fax number: • For Blue Cross Blue Shield of Michigan commercial, fax to 1-800-482-1713. • For Blue Care Network commercial, fax to 1-866-313-8433. For timely processing, include the pertinent clinical documentation. You can access the form on the **ereferrals.bcbsm.com** website, on these pages: • **Blue Cross Acute Inpatient Medical and Surgical Admissions** • **BCN Acute Inpatient Medical and Surgical Admissions**
Retroactive authorization requests for inpatient admissions that started as outpatient services	Use the e-referral system to submit a retroactive authorization request for each inpatient admission.
Adjustments in dates of service for procedures managed by vendors such as TurningPoint Healthcare Solutions LLC	Submit this information to the vendor that manages the procedure. For information about submitting requests to vendors, visit **ereferrals.bcbsm.com**.

TurningPoint Healthcare Solutions LLC is an independent company that manages authorizations for musculoskeletal surgical and related procedures for Blue Cross Blue Shield of Michigan and Blue Care Network.

Referral Roundup

Changes coming to prior authorization process for post-acute care services for Medicare Advantage members

In fourth-quarter 2024, Home & Community Care (formerly known as naviHealth, Inc.) will no longer manage prior authorizations for post-acute care services for Medicare Plus Blue℠ and BCN Advantage℠ members.

Post-acute care services will continue to require prior authorization, but the prior authorizations will be managed by Blue Cross Blue Shield of Michigan and Blue Care Network.

Watch for provider alerts and articles in *BCN Provider News* with additional information about this change, including:

- Training, which will include program requirements and more
- Updates to our provider communications and documents for this program

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.

Procedure codes that require prior authorization through BCN

We've removed the document titled *BCN-managed procedure codes that require authorization for Michigan providers*.

To determine whether a procedure code requires prior authorization from Blue Care Network, see the document titled **Procedure codes for which providers must request prior authorization**. This document provides a detailed list of CPT* codes and HCPCS codes for services that require prior authorization for most members. Procedure codes that are managed by BCN, "BCNA," "HMO" or "BCNA | HMO" appear in the *Lines of business* column and "e-referral" appears in the *Requests managed by* column.

We'll use 2024 InterQual criteria starting Aug. 1

On Aug. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2024 InterQual® criteria to make determinations on prior authorization requests for the medical (non-behavioral health) services we manage for these members:

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

Note: If InterQual criteria are updated to correct known issues or errors, we'll use the updated criteria as soon as they're available.

Blue Cross and BCN also use Local Rules for post-acute care (inpatient rehabilitation, skilled nursing facility and long-term acute care) prior authorization requests. These Local Rules are modifications of InterQual criteria that we use in making determinations. You can access the Local Rules on the **Services that need prior authorization** page on **bcbsm.com**. We're updating that page to include the most current version of the Local Rules.

Refer to the table below for more specific information about which criteria we use in making determinations for various types of non-behavioral health prior authorization requests.

Criteria	Services
InterQual acute — Adult and pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual level of care — Subacute and skilled nursing facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual rehabilitation — Adult and pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual level of care — Long-term acute care	• Long-term acute care facility admissions • Continued stay discharge readiness
InterQual imaging	Imaging studies and X-rays
InterQual procedures — Adult and pediatrics	Surgery and invasive procedures
Medicare coverage guidelines (as applicable)	Services that require clinical review for medical necessity and benefit determinations
Blue Cross and BCN medical policies	Services that require clinical review for medical necessity
Local Rules for post-acute care (applies to inpatient rehabilitation, skilled nursing facility and long-term acute care admissions for Blue Cross commercial and BCN commercial)	Exceptions to the application of InterQual criteria that reflect the accepted practice standards for Blue Cross and BCN

When clinical information is requested for a medical or surgical admission or for other services, we require providers to submit specific components of the medical record that show that the request meets the criteria. We review this information when making determinations on prior authorization requests.

Note: This information applies to members whose authorizations are managed by Blue Cross or BCN directly and not by independent companies that provide services to Blue Cross or BCN.

Questionnaire changes in the e-referral system

On March 31 and April 28, 2024, we added and updated questionnaires in the e-referral system.

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

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 questionnaire

On March 31, we added the following questionnaire to the e-referral system.

Questionnaire	Opens for	Updates
Endoscopic bypass E&I trigger	• BCN commercial • BCN Advantage	Opens for procedure codes *43644 and *43645.

Updated questionnaires

We updated the following questionnaires in the e-referral system on the date specified below.

Questionnaire	Opens for	Updates	Release date
Cosmetic or reconstructive surgery	BCN commercial	No longer opens for BCN Advantage or Medicare Plus Blue.	3/31/2024
Dental general anesthesia	BCN commercial	• No longer opens for BCN Advantage. • Updated two questions. • Removed one question.	3/31/2024
Dental general anesthesia or dental services trigger	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Dental services	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Excess skin removal	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Facial feminization surgery and chondrolaryngoplasty	BCN commercial	• The name of the questionnaire was changed to *Facial feminization surgery*. • The questionnaire no longer opens for procedure codes *21120, *21121, *21122, *21123, *21125, *21127, *21137, *21138, *21139, *21209, *30400, *30410, *30420 and *31559. However, these procedure codes continue to require prior authorization.	4/28/2024
Orthognathic surgery	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Responsive neurostimulator / deep brain stimulation trigger	• BCN commercial • BCN Advantage	Updated a question.	3/31/2024
Surgical treatment for male gynecomastia	• BCN commercial • BCN Advantage	Updated a question in the BCN commercial questionnaire.	3/31/2024

Please see Questionnaire changes continued on Page 36

Referral Roundup

Questionnaire changes,

continued from Page 35

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.

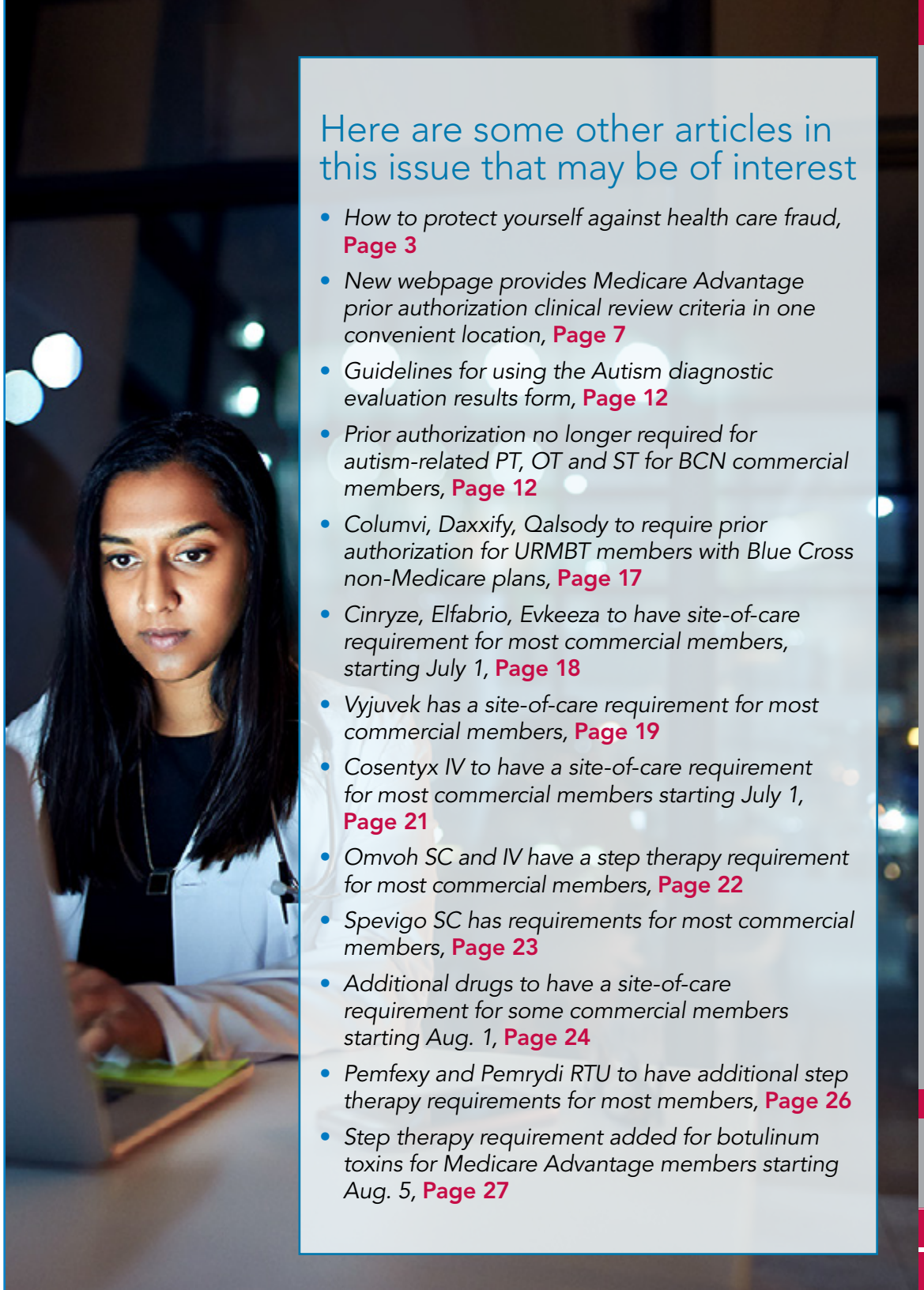
To find the preview questionnaires, see the document titled **Authorization criteria and preview questionnaires**.

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.



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

Changes coming for select weight loss drugs for some commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network are changing how we approach coverage of glucagon-like peptide-1 receptor agonist, known as GLP-1, drugs indicated for weight loss for our fully insured large group commercial members. These drugs include:

- Saxenda® (liraglutide)
- Wegovy® (semaglutide)
- Zepbound® (tirzepatide)

Here's what will change:

- **Aug. 1, 2024** – Prior authorizations for these drugs will end at midnight on July 31. A new prior authorization request will be required, and new prior authorization criteria will be applied for these members for dates of service from Aug. 1 through Dec. 31, 2024. Some members will require a new prescription to align with the new prior authorization criteria if the original prescriber didn't have an established relationship with the member or hasn't seen the member in person. For members with a plan renewal date other than Jan. 1, the new prior authorization will end prior to the renewal date.
- **Jan. 1, 2025** – Coverage for GLP-1 weight loss drugs for fully-insured large group commercial members will end starting Jan. 1, 2025. For group members with a plan renewal date other than Jan. 1, the coverage will end on the renewal date.

We're notifying the members affected by these changes and their prescribers.

We're changing prior authorization criteria

For dates of service from Aug. 1 through Dec. 31, 2024, Saxenda, Wegovy and Zepbound will have new prior authorization criteria for fully insured large group commercial members.

All current authorizations for these medications for these members will expire on July 31, 2024.

The following new criteria will apply for fully insured large group commercial members:

- The member must be 18 years or older and have a body mass index of 35 or higher.
- The medication must be prescribed by a health care provider who has an established relationship with the member and has seen the member in person.
- The prescriber must document the member's current baseline weight (within 30 days).
- The prescriber must document the member's active participation in a lifestyle modification program (working with a coach, tracking food and exercising) for a minimum duration of six months before the prior authorization request. The prescriber will no longer be able to attest to a member's participation. The prescriber must submit documentation, or the request will be denied.
- The member must enroll and participate in the **Teladoc® Health program for weight management**. This is a program at no cost to eligible members that offers easy-to-use tools and support. The prescriber must submit documentation of the member's active participation, or the request will be denied.

In addition to the requirements above, Saxenda, Wegovy, and Zepbound:

- Can't be used in combination with other weight loss products or other products that contain GLP-1 agonists
- Aren't covered for members with Type 2 diabetes

Please see Changes coming for select weight loss drugs continued on Page 38

Changes coming for select weight loss drugs,

continued from Page 37

For more information on how to submit a prior authorization electronically:

1. Go to **ereferrals.bcbsm.com**.
2. Select *Blue Cross* for PPO members or *BCN* for HMO members.
3. Click *Pharmacy Benefit Drugs* in the left navigation.
4. See the section, "How to submit an electronic prior authorization, or ePA, request."

What you need to do

If you have Blue Cross or BCN commercial members with a current prior authorization for Saxenda, Wegovy or Zepbound, ask the member if he or she is affected by this change. The member will know they're affected if they receive a letter from Blue Cross. The member can also check their Blue Cross member app or call the customer service number on their ID card.

If the member is affected, you'll need to submit a new prior authorization request following the new requirements for dates of service beginning Aug. 1, 2024. Based on the new requirements, the member may require a new prescription. If the new coverage requirements are not met, or the documentation noted above is not included in the prior authorization request, these Blue Cross and BCN members will no longer qualify for coverage.

We're changing coverage

Beginning Jan. 1, 2025, Blue Cross and BCN will no longer cover any GLP-1 drug for weight loss for fully insured large group commercial members. For group members with a plan renewal date other than Jan. 1, this change will go into effect on the renewal date.

This applies to all GLP-1 weight loss drugs, including Saxenda, Wegovy and Zepbound.

If you keep a member who is affected by this change on a GLP-1 drug for weight loss, that member will be responsible for the full cost of the drug.

We'll update our drug criteria documents

The following documents will be updated to reflect these changes as they occur:

- **Blue Cross PPO and BCN HMO prior authorization and step therapy coverage criteria**
- **Blue Cross PPO and BCN HMO prior authorization and step therapy coverage criteria for the Preferred Drug List**

Why Blue Cross and BCN are making these changes

We're making these changes in part because research has shown that a person's chance of success in losing weight and maintaining that weight loss is greatly improved when medication is paired with lifestyle changes, including diet and exercise.[1,2] This is why we're requiring that members on Saxenda, Wegovy or Zepbound participate in the weight management program through Teladoc Health.

In addition, prescription medications need to be effective as well as safe. Data published by the Blue Cross Blue Shield Association in May 2024 shows that most patients aren't staying on weight loss GLP-1 drugs long enough to see a benefit.[3] Due to the high cost of these drugs and supply considerations, we want to ensure they are used for the most appropriate patients who can achieve clinical benefit. Additional research is needed to understand whether GLP-1 interventions lead to lower medical costs in the long term.

Questions?

If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803.

[1]Jensen, S. B., Blond, M. B., Sandsdal, R. M., Olsen, L. M., Juhl, C. R., Lundgren, J. R., Janus, C., Stallknecht, B. M., Holst, J. J., Madsbad, S., & Torekov, S. S. (2024). **Healthy weight loss maintenance with exercise, GLP-1 receptor agonist, or both combined followed by one year without treatment: A post-treatment analysis of a randomised placebo-controlled trial**. *eClinicalMedicine, 69*, 102475. https://doi.org/10.1016/j.eclinm.2024.102475

[2]Dalle Grave, R. (2024). **The benefit of healthy lifestyle in the era of new medications to treat obesity**. *Diabetes, Metabolic Syndrome and Obesity, 17*, 227-230. https://doi.org/10.2147/dmso.s447582

[3]Blue Cross Blue Shield Association, Blue Health Intelligence Issue Brief (May 2024). **Real-World Trends in GLP-1 Treatment Persistence and Prescribing for Weight Management**. Retrieved from https://www.bcbs.com/sites/default/files/BHI_Issue_Brief_GLP1_Trends.pdf

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BCN Provider News

Coming soon: Facilities and organizational providers can update information in the Provider Data Management tool within Availity Essentials

Per the Consolidated Appropriations Act, providers must update and attest to the accuracy of their provider directory data every 90 days — even if no changes are needed. In the past, Blue Cross Blue Shield of Michigan and Blue Care Network have sent letters to providers to request attestation of this information.

Soon, existing facilities and organizational providers (also known as allied providers) with Type 2 NPIs will be required to update and attest to the following basic provider information in the Provider Data Management tool in our provider portal, Availity Essentials™:

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

Updating this information in our provider portal will update our provider directory. Failure to complete the quarterly attestation will result in being removed from our provider directory and may affect our ability to process claims on your behalf.

To learn which providers are organizational providers, see "Which providers are organizational providers" later in this article.

Important:

- Facilities and organizational providers who need to update information other than the items listed above will have to submit the applicable change form. To access the change forms, go to **bcbsm.com/providers**, click *Enrollment*, click the *Enroll or Make Changes* button, select your classification type and then do the following:
  - If you selected *Hospital and Facilities*, click *Next*, select the appropriate type of facility and click *Next* again. Click the link for the appropriate change form.

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BCN Provider News

- If you selected *Physicians and Professionals*, click *Next*, click *Change an existing provider* and click *Next* again. Click the appropriate option under *Organizational/ Allied Providers* and click *Next*. Click the link for the appropriate change form.

- The change described above won't affect group providers or individual practitioners. Group providers should continue to use the Provider Enrollment and Change Self-Service tool. Physician and nonphysician practitioners should continue to use the CAQH Provider Data Portal application (formerly known as CAQH ProView®) and change forms found on **bcbsm.com**.

We'll publish additional information in an upcoming provider alert and *BCN Provider News*.

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.

Which providers are organizational providers

Organizational providers, also known as allied providers, are:

- Ambulance
- Ambulatory surgical facility
- Clinical independent laboratory
- Durable medical equipment supplier
- Freestanding radiology center
- Independent diagnostic testing facility
- Pharmacy — Not affected by this change
- Physiological laboratory
- Private duty nursing
- Prosthetic and orthotic supplier
- Retail health center
- Urgent care center
- Vaccine pharmacy

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Network Operations

Change Healthcare's incident and its potential effect on members

Earlier this year, Change Healthcare experienced a cybersecurity incident that affected the ability of many of our health care provider partners to handle daily transactions. Change Healthcare is an independent company that serves as a clearing house, supporting core transactions for health care providers, such as eligibility and benefit checks and claims submission.

On June 20, 2024, Change Healthcare issued a public notice formally declaring a breach of protected health information. Change Healthcare indicated that it will take full responsibility for all required breach notifications and will begin notifying individuals. If your office was affected by the incident, it is likely that some of your patients may receive a letter from Change Healthcare in the coming months notifying them that their personal or health information may have been involved. Change Healthcare will offer them two years of free credit monitoring and identity theft protection.

More information can be found on **Change Healthcare's website** or the **Change Healthcare Cyberattack webpage** set up for individuals whose data may have been affected. Questions can be directed to the Change Healthcare call center at 1-866-262-5342.

Here are provider alerts related to the Change Healthcare incident:

- **Support for providers using Change Healthcare as their EDI Clearinghouse**
- **We're granting a 90-day extension to the time limit for commercial claim submission**
- **We're reprocessing some claims denied for timely filing for Blue Cross and BCN commercial**

Network Operations

New enhancements to member portal for prior authorization and referral process coming soon

Blue Cross Blue Shield of Michigan and Blue Care Network are pleased to announce three new enhancements to the member portal scheduled to launch in October 2024. Each enhancement is designed to provide greater transparency for members regarding the prior authorization and referral process, including:

- Notifications sent to members by email, text message or mobile app push notification indicating when a prior authorization or referral request was received, is in review and when a request has been approved, partially approved or not approved.
- The ability for members to view real-time status updates for submitted prior authorization and referral requests through an at-a-glance status tracker.
- Additional information and guidance added to help members understand the prior authorization and referral process and what it means for them.

We continue to encourage members to engage with their providers during the prior authorization and referral process.

Be sure to check future issues of *BCN Provider News* for more information on these exciting member portal enhancements.

Register now for Prior Authorization Programs with Carelon webinar

Provider office personnel responsible for obtaining prior authorizations are encouraged to register now for an intermediate webinar about Blue Cross' utilization management program partnered with Carelon Medical Benefits Management (formerly AIM Specialty Health).

Carelon performs medical appropriateness reviews for the following services: high-tech radiology, cardiology, radiation oncology, medical oncology and in-lab sleep studies. Prior authorization programs vary based on the member group contract and benefits.

This live session will present an educational overview of all the programs and a quick review demonstration of the Carelon portal. This webinar will build on the first webinar held earlier this year to deep dive into some intermediate topics such as denials and appeals. The presentation is followed by a Q&A period. You can register for this webinar on the provider training website.

Session	Date	Time
Prior Authorization Programs with Carelon	October 10	10 - 11 a.m. Eastern time

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*. Log in through **availity.com**.

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

After logging in to the provider training website, go to the *Event Calendar* to register. You may also search for all the sessions with the keyword 'Carelon' and then look under the results for Events.

Questions?

For more information about registration or 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.

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.

Webinars for physicians, coders focus on risk adjustment, coding

We're offering webinars about 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 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
Sept. 18	Neurosurgery, Dementia and Cognitive Impairment Coding Tips
Oct. 2	ICD-10-CM Updates
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 **here** if you don't have a provider portal account.

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 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

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 "**Access our training site from our provider portal; new learning path available**."

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.

New training opportunities available on provider training site

Action item

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

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

We added the following learning opportunities:

- **Find a doctor mini module**

  Providers may find it helpful to know the networks they support. Take this mini module to learn how to quickly look up the list of networks, which helps answer questions from patients and during audits.
- **New provider resource guides**

  We updated the guides for new providers. Use the keyword search to find guides for acupuncturists, athletic trainers, behavioral health professionals, genetic counselors and private duty nurses.

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**.

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

- *Change Healthcare's incident and its potential impact on members*, **Page 3**
- *Physician appointment access survey in process*, **Page 10**
- *Quality Minute – CPT II codes*, **Page 33**

BCN Advantage

Select Medicare Advantage members will receive kidney health evaluation test kits from Everlywell in early September

Blue Cross Blue Shield of Michigan and Blue Care Network are partnering with Everlywell, a third-party vendor, to distribute in-home test kits to select Medicare Advantage members with diabetes. If your patients receive an advance notice letter about the kits and have questions, please encourage them to take advantage of this convenient, no-cost testing.

Kidney Health Evaluation for Patients with Diabetes (KED) is a HEDIS® measure that evaluates the percentage of diabetic patients who received both a serum estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR) during the measurement year. Members will receive eGFR kits and/or uACR kits depending on which aspect of the measure they are non-compliant. If a member is targeted for eGFR, their blood sample will also be tested for Hemoglobin A1c, if needed.

Members will be encouraged to discuss test results with their primary care providers.

Test result notification:

	Normal results	Abnormal results
Medicare Advantage Member	Mail	Mail and phone call (Certified letter if unable to reach)
Primary Care Provider	Direct Trust EMR Messaging or Fax (providers without a Direct Trust account)	

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 will 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's changing

When this change goes into effect on Oct. 1:

- Medicare Plus Blue and BCN Advantage members who receive their CGM products through a DME supplier will require a new prescription to be filled at a pharmacy.
- Participating pharmacies will be 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 will be billed under the members' medical benefits, not their pharmacy benefits.

Note: Current coverage criteria will still apply.

Additional information

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

We'll update our provider manuals and related documents by Oct. 1 to reflect this change.

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

Physician appointment access survey in process

Blue Cross Blue Shield of Michigan and Blue Care Network must meet requirements of several regulatory or accreditation bodies, such as the National Committee for Quality Assurance, the Centers for Medicare & Medicaid Services and the state of Michigan. To help ensure we meet these requirements, we're reaching out to some physician offices to request that you complete an *Appointment Access Survey* for each physician in the office.

Your office may receive a phone call or a fax request to complete the survey. Your participation is important to demonstrate that you're meeting regulatory requirements.

Below are the physician specialties that will be included in the survey. If you have physicians with these specialties at your office, you can follow the instructions below to complete the survey before we contact you.

Primary care Complete survey by Sept. 15, 2024	**Specialists** Complete survey by Nov. 30, 2024
• Family practice • General practice • Internal medicine • Pediatrics	• Cardiology • Dermatology • Obstetrics-gynecology • Oncology • Ophthalmology • Orthopedic surgery • Podiatry

Note: Be sure to complete a separate survey for each physician in the office.

Continued on following page

How to access the survey

Type of physician	Click this link	Or scan this QR code
Primary care	**Primary Care Appointment Access Survey**	
Specialist	**Specialist Appointment Access Survey**	

Review appointment access standards

You can review appointment access standards in our provider manuals. Here's how to find them.

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

For the ***Blue Cross Commercial Provider Manual***:

1. Click on *Blue Cross commercial*.
2. Scroll down to the *PPO Policies* chapter under *Quality Standards and Clinical Guidelines*.
3. Click on *Appointment access standards for primary care providers and specialists* in the table of contents.

For the ***BCN Provider Manual***:

1. Click on *BCN commercial and BCN Advantage℠*.
2. Scroll down to the *Access to Care* chapter.

For the ***Medicare Plus Blue℠ PPO Provider Manual***:

1. Click on **Medicare Plus Blue℠ (PDF)**.
2. Click on *Access to Care* in the table of contents.

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

Blue Cross and BCN is covering an additional vaccine

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

Common Name	Vaccine	Effective date
Pneumococcal conjugate (PCV21)	Capvaxive™	June 20, 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 cost sharing.

Vaccines with age requirements

Common Name	Vaccine
Human Papillomavirus Vaccine (HPV)	Gardasil9® 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®

Continued on following page

Common Name	Vaccine
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, B, C, W, Y vaccine (MenACWY-TT/ MenB-FHbp)	Penbraya™
Meningococcal serogroups A, C, W, Y (MenACWY-CRM)	Menveo®
Meningococcal serogroups A, C, W, Y (MenACWY-TT)	MenQuadfi®
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®
Respiratory syncytial virus (RSV)	• Abrysvo™ • Arexvy®
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.

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.

Transitions of Care (TRC)

- If a member is transferred from an inpatient stay to a skilled nursing facility, follow up should occur following the discharge from the SNF. Over half of the SNFs in Michigan are sending admissions, discharges and transfers through the Michigan Health Information Network. We expect this to increase as Blue Cross Blue Shield of Michigan and Blue Care Network continues outreach to SNFs to encourage sending of ADTs.
- 1111F can be billed as soon as medication reconciliation is performed and documented in the patient's outpatient medical record. Therefore, you do not need to wait for an office visit or all components of a transitional care management (TCM) visit to be complete to bill 1111F.
- 1111F is reimbursable for Medicare Advantage patients and there is no member cost share.
- TCM codes will satisfy both the Patient Engagement and Medication Reconciliation Post-Discharge components of TRC.

Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)

- Members will be in the denominator after each emergency department visit and could be in the denominator more than once.
- Blue Cross and BCN have worked with MiHIN to develop new ADT flags that identify high-risk member discharges for prompt post-discharge follow-up care.

For more information, see the **Transitions of Care (TRC)** or **Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)** tip sheets. Here's how to find them.

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

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:

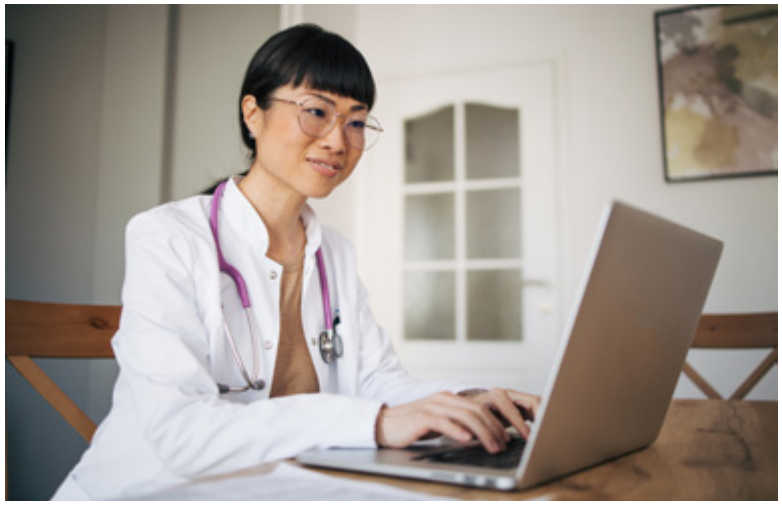
Covered services

- Artificial intervertebral discs – lumbar spine
- BMT – HCT for autoimmune diseases
- Bone morphogenetic protein
- Bronchial valves
- Cardiac rehabilitation, outpatient
- Cognitive rehabilitation
- Diagnosis of vaginitis
- Fecal microbiota transplantation (fecal bacteriotherapy, fecal transplant)
- Genetic testing for FLT3, NPM1, CEBPA, IDH1 and IDH2 variants in Acute Myeloid Leukemia
- Hearing services
- Hyperbaric oxygen therapy, systemic and topical
- Intravitreal and punctum corticosteroid implants
- Laboratory tests post transplant (kidney, heart and lung) and for heart failure
- Microprocessor-controlled prostheses and orthoses for lower limb
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Transplant – small bowel (isolated)
- Transplant – heart
- Transcatheter Aortic Valve Implantation for aortic stenosis
- Transcranial Magnetic Stimulation as a treatment of depression and other psychiatric/neurologic disorders

Noncovered services

- Surgical deactivation of headache trigger sites

Medical Policy Updates



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

- *New enhancements to member portal for prior authorization and referral process coming soon,* **Page 4**
- *Select Medicare Advantage members will receive kidney health evaluation test kits from Everlywell in early September,* **Page 8**
- *Medicare Advantage members must obtain continuous glucose monitor products through a pharmacy, starting Oct. 1,* **Page 9**
- *Updated provider toolkit for treating depression available,* **Page 17**

Blue Cross Behavioral Health no longer requires autism diagnostic re-evaluations

As of Jan. 1, 2024, Blue Cross Behavioral Health℠ no longer requires a diagnostic re-evaluation by an approved autism evaluation center or by independent providers every three years. Diagnostic re-evaluations are optional and can be completed based on clinical need during treatment.

Here are the current guidelines:

- An initial diagnostic evaluation is required prior to treatment, to establish an autism diagnosis and identify possible treatment needs.
- A diagnostic re-evaluation is **optional**, based on clinical need.

Prior to Jan. 1, 2024, a diagnostic re-evaluation was required every three years. That requirement is no longer in effect.

Note: This doesn't affect the reassessments that licensed behavior analysts and others complete as needed once autism treatment has begun.

We've updated these documents to include this information:

- **Obtaining an autism diagnostic evaluation and finding treatment**
- **Autism diagnostic evaluation results form**
- **Blue Cross Behavioral Health: Frequently asked questions for providers**

These documents and other autism-related resources are available on these webpages on our **ereferrals.bcbsm.com** website:

- **BCN Autism Services**
- **Blue Cross Autism Services**

Updated provider toolkit for treating depression available

With many members seeking treatment for depression through their primary care providers, Blue Cross Blue Shield of Michigan's Behavioral Health Strategy department has updated the Depression Toolkit for Providers that is now available through the Blue Cross Behavioral Health Provider website or by clicking on the links below.

There are three components to this toolkit:

1. **Tip Sheet for Major Depressive Disorder**

   This document provides guidelines for evaluating, treating, and monitoring members' depressive symptoms as well as additional resources for helping members locate behavioral health specialists and for when collaboration with specialists would be indicated.

   Included in the list of treatment options for members are links to the Quartet, Blue Cross Virtual Care, and AbleTo platforms which can assist members in receiving care from in-network behavioral health providers so that they can find quality care in a timely manner to further bolster the treatment they receive from their primary care provider.

2. **Depression Office Flyer for members**

   This document helps members to understand how primary care providers will treat their depression. This is a single-sheet document that is suitable for sending to members via email or printing for them to take away at the end of an office visit.

3. **Depression Brochure for members**

   This document helps members identify symptoms of depression, and also provides additional community resources that they can access for help and further assistance. This document is also suitable for emailing to members or printing for them to take away at the end of an office visit.

With these updated guides, Blue Cross Blue Shield and Blue Care Network of Michigan reaffirm its commitment to partnering with our providers to help them deliver effective, timely treatment to members to help them manage their holistic medical and behavioral health needs.

Reminder: Medicare Advantage members in crisis have new options for behavioral health care treatment

Starting Jan. 1, 2024, our Medicare Advantage members (Medicare Plus Blue℠ and BCN Advantage℠) have some new options for receiving help if they're having a behavioral health crisis, as part of our crisis services program.

"These options can be used in place of going to an emergency room in an effort to hasten access to behavioral health-focused care," said Dr. William Beecroft, medical director of behavioral health for Blue Cross Blue Shield of Michigan.

Blue Cross and Blue Care Network commercial plans began offering this program in October 2021.

Care options include:

- Psychiatric urgent care
- Mobile crisis services
- On-site crisis stabilization services
- Residential crisis treatment

Several facilities in Michigan currently offer these services as part of this program, with additional facilities expected to join the program in the future.

See our ***Help in times of crisis*** flyer for details on locations, phone numbers, service areas and care options available at these locations.

In a crisis, members or other individuals — including family members, friends, law enforcement personnel or emergency department staff — can call the number of a crisis location in their service area for guidance. A mobile unit may be deployed to offer assessment and treatment. Walk-ins are also accepted at some locations.

"The goal of such services is to make sure our members get treated at the right place at the right time," Dr. Beecroft said.

About our mobile crisis services

Mobile crisis services include:

- Professional mental health teams in the community who can evaluate the members wherever they are located — even in their homes, school, work or doctor's office
- Face-to-face evaluations, telemedicine or phone evaluations to develop a treatment plan, initiate treatment and, if needed, referral to an appropriate placement for the member

The mobile crisis team may stay involved for two to four weeks after the initial encounter to ensure members are connected to the right level of care for mental health or substance use disorder treatment, and to provide treatment as necessary.

About our on-site crisis stabilization services

On-site crisis stabilization services include:

- Behavioral health evaluation to initiate appropriate treatment (similar to medical observation services)
- Physical site-based services that are necessary to support the mobile crisis team

  Includes intake assessment, psychiatric evaluation, crisis intervention and initiation of treatment, such as psychotherapy, medication administration, therapeutic injection, observation and peer support
- Initiating coordinated linkages and "warm handoffs" to the appropriate level of care and community resources

Facilities used for physical site-based services are open 24/7. Members will have access to services from a multidisciplinary staff, including physicians, registered nurses, licensed master social workers, psychologists, clinical supervisors and additional support staff.

As part of the evaluation and treatment process at these facilities, some members may still need psychiatric hospitalization.

Management of medical and pharmacy benefit oncology drugs moving to OncoHealth for most members, starting Jan. 1

For dates of service on or after Jan. 1, 2025, OncoHealth® will manage prior authorizations for oncology drugs through the Oncology Value Management program.

OncoHealth will manage:

- **Medical benefit oncology drugs**, which are managed by Carelon Medical Benefits Management for dates of service before Jan. 1, 2025

  Note: Blue Cross Blue Shield of Michigan and Blue Care Network will continue to manage prior authorization requests for gene and cellular therapies, such as CAR-T.

- **Pharmacy benefit oncology drugs**, which are managed by Blue Cross and BCN for dates of service before Jan. 1, 2025

Coupling the review of medical benefit and pharmacy benefit oncology drugs will help to reduce the administrative burden on providers and streamline patient care.

OncoHealth will manage the following:

- Prior authorizations — Will include reviewing requests for medical necessity, preferred drugs, step therapy requirements, dose optimization, split fills and quantity limits
- Site of care transitions from higher- to lower-cost places of service — For Blue Cross and BCN commercial members only

This change will affect the following groups and members:

- Blue Cross commercial
  - Fully insured groups and individual members

    Exception: MESSA won't be participating in the Oncology Value Management program for medical benefit drugs.
  - Self-funded groups

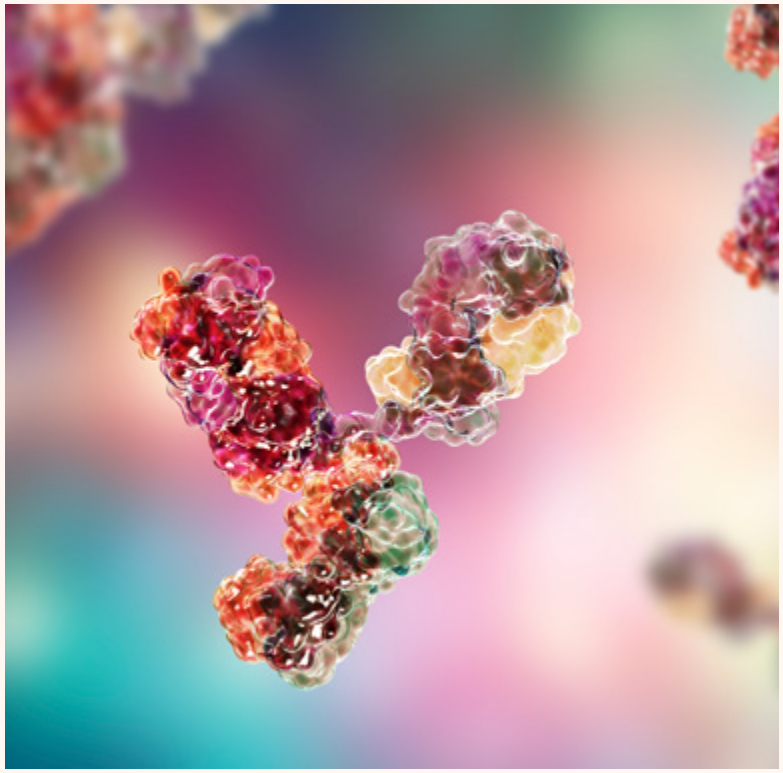
    Note: The Oncology Value Management program changes won't apply to Blue Cross commercial UAW Retiree Medical Benefits Trust non-Medicare members or to Blue Cross and Blue Shield Federal Employee Program® members. Their medical benefit and pharmacy benefit oncology drugs will continue to be managed as they are today.
- Medicare Plus Blue℠ members
- BCN commercial members
- BCN Advantage℠ members

Watch for additional provider alerts and newsletter articles about this change, including how to register for webinars.

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.

We're changing how we manage immunoglobulin therapies for most commercial members, starting Oct. 1



For dates of service on or after Oct. 1, 2024, the drugs listed below will be the preferred immunoglobulin products for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members:

- Gammagard®, liquid and S/D, (immune globulin), HCPCS codes J1566 and J1569
- Hizentra® (immune globulin), HCPCS code J1559
- Octagam® (immune globulin), HCPCS code J1568

Here's how these products are covered:

- Gammagard, Hizentra and Octagam will continue to be covered under medical benefits when administered by a health care professional.
- Gammagard and Hizentra will continue to be covered under pharmacy benefits when self-administered.

How this will affect members

Here's important information you'll need to know:

- Members who have active authorizations for the **preferred** immunoglobulin products won't be affected by this change.
- For members who have active authorizations for **nonpreferred** immunoglobulin products:
  - These members are authorized to continue their current therapy through Sept. 30, 2024.
  - We've proactively issued authorizations for the **preferred** products from Oct. 1, 2024, through Sept. 30, 2025, to avoid any interruptions in therapy. You won't need to submit prior authorization requests for the preferred products for dates of service within this time frame.
  - We'll mail letters to members who are currently using nonpreferred products to notify them of these changes.
  - For members who will continue to use a nonpreferred immunoglobulin product on or after Oct. 1, you'll need to submit a new prior authorization request.

How to submit prior authorization requests

You'll submit prior authorization requests differently depending on how the medication is administered, as follows:

- For an immunoglobulin product that requires administration by a health care professional, submit the request through the NovoLogix® online tool.
- For a self-administered immunoglobulin product, submit the request using an electronic prior authorization, or ePA, tool such as CoverMyMeds® or Surescripts®.

Continued on following page

Some Blue Cross commercial groups aren't subject to this requirement

For Blue Cross commercial, this requirement applies only to groups that participate in the standard commercial 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**.

Notes:

- The changes discussed above apply to Blue Cross commercial UAW Retiree Medical Benefits Trust members with non-Medicare plans. However, they don't apply to the UAW Retiree Health Care Trust (group number 70605) or the UAW International Union (group number 71714).
- Blue Cross and Blue Shield Federal Employee Program® members don't participate in the standard prior authorization program.

List of requirements

For more information about the requirements related to drugs covered under **medical benefits**, see these lists:

- For Blue Cross commercial URMBT members with non-Medicare plans: **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
- For most other commercial members: **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**

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

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

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

We'll change how we pay for some brand-name drugs that have a generic equivalent available, starting October 1

Starting October 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer pay for the brand-name drugs on the following list because they have a generic equivalent available.

Members who currently receive one of these brand name drugs may need a new prescription to fill the generic. If they're already taking the generic, they can simply continue to fill their current prescription.

Continued on following page

Common use or drug class	Brand name drugs that won't be covered	Covered generic equivalent
Androgens	Androgel® pump	testosterone transdermal gel
Antileukotrienes	Singulair®	montelukast tablet, chewable, granules
Antiviral	Valtrex®	valacyclovir tablet
Benzodiazepines	Ativan®	lorazepam tablet
	Xanax®, XR	alprazolam, alprazolam XR tablet
Cystic Fibrosis	Bethkis®	tobramycin nebulizer solution
Dyslipidemic	Lovaza®	omega-3-acid ethyl ester capsule
	Vytorin®	ezetimibe-simvastatin tablet
	Zetia®	ezetimibe tablet
Erectile Dysfunction	Cialis®	tadalafil tablet
	Viagra®	sildenafil tablet
HMG CoA Reductase Inhibitors	Crestor®	rosuvastatin tablet
	Lescol XL®	fluvastatin tablet
	Lipitor®	atorvastatin tablet
	Zocor®	simvastatin tablet
Multiple Sclerosis	Ampyra®	dalfampridine ER tablet
	Aubagio®	teriflunomide tablet
	Gilenya®	fingolimod capsule
	Tecfidera®	dimethyl fumarate capsule
Non-steroidal anti-inflammatory (NSAID)	Celebrex®	celecoxib capsule
Oncology	Gleevec®	imatinib tablet
Opioids, short-acting	Percocet®	oxycodone/acetaminophen tablet
Proton pump inhibitors	Aciphex®	rabeprazole tablet
	Dexilant®	dexlansoprazole capsule
	Nexium® capsule and packet	esomeprazole capsules and packets
	Prevacid®, Prevacid® solutab	lansoprazole capsule and oral disintegrating tablet
	Protonix® tablet and packet	pantoprazole tablet and packet

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

Pharmacy News

Loqtorzi has requirements for most members

For dates of service on or after Aug. 15, 2024, Loqtorzi™ (toripalimab-tpzi), HCPCS code J3263, has the following requirements through the Oncology Value Management program:

- **For Blue Cross Blue Shield of Michigan and Blue Care Network commercial members**: Loqtorzi has both a prior authorization requirement and a site-of-care requirement.
- **For Medicare Plus Blue℠ and BCN Advantage℠ members**: Loqtorzi has a prior authorization requirement.

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

Prior authorization requirement

Prior authorization requirements apply when these drugs are administered in outpatient settings for:

- Blue Cross 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
- BCN commercial members
- BCN Advantage members

Continued on following page

Site-of-care requirement

For the commercial members listed above, this drug may be covered only when administered at the following sites of care for dates of service on or after Aug. 15:

- Doctor's or other health care provider's office
- The member's home, administered by a home infusion therapy provider
- Ambulatory infusion center

Here's what to do for commercial members who receive Loqtorzi at an outpatient hospital facility for dates of service before Aug. 15:

- Locate an in-network home infusion therapy provider or ambulatory infusion center at which the member may be able to continue infusion therapy.
- Discuss with the member how to facilitate receiving infusions at an allowed site of care.

For members who need to transition to a new infusion location, we'll work with you and the member to facilitate the transition. We'll notify members and encourage them to talk to you before changing their infusion location. We'll also let them know that the change of location doesn't affect the treatment you're providing.

How to submit prior authorization requests

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

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

Drug lists

For additional information on requirements related to drugs covered under medical benefits, 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**

As a reminder, prior authorization isn't a guarantee of payment. Health care providers 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.

Step therapy requirement added for Saphnelo for Medicare Advantage members, starting Sept. 1

For dates of service on or after Sept. 1, 2024, providers will have to show that our Medicare Plus Blue℠ and BCN Advantage℠ members tried and failed Benlysta® (belimumab), HCPCS code J0490, when requesting prior authorization for Saphnelo® (anifrolumab-fnia), HCPCS code J0491.

Note: Benlysta will continue to require prior authorization.

Submit prior authorization requests through the NovoLogix® online tool.

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

When prior authorization is required

These drugs require prior authorization, as applicable, when they're administered by a health care provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

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

Submit prior authorization requests through NovoLogix

To access NovoLogix, log in to our provider portal (**availity.com**), click on *Payer Spaces* in the menu bar and then click on 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 medical benefits, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**.

We'll update this list before 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.

Soliris, Ultomiris to require step therapy for commercial members

For dates of service on or after July 22, 2024, members must try and fail — or have a contraindication or intolerance for — Empaveli® (pegcetacoplan), HCPCS code J3590, before we'll approve prior authorization requests for the following drugs:

- Soliris (eculizumab), HCPCS code J1300
- Ultomiris (ravulizumab), HCPCS code J1303

This step therapy requirement applies to most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members and is in addition to the other requirements that currently apply to Soliris and Ultomiris.

Prior authorization information

- When you submit prior authorization requests for Soliris and Ultomiris, the NovoLogix® online tool will prompt you to answer questions related to the step therapy requirement.
- Prior authorization is also required for Empaveli.

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial 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 members with Blue Cross non-Medicare plans don't participate in the standard prior authorization program.

Step therapy requirements added for Soliris, Ultomiris for Medicare Advantage members with PNH, starting Sept. 16

For dates of service on or after Sept. 16, 2024, providers will have to show that our Medicare Plus Blue℠ and BCN Advantage℠ members have tried and failed Empaveli® (pegcetacoplan), HCPCS code J3490, when requesting prior authorization for the following drugs for the diagnosis of **paroxysmal nocturnal hemoglobinuria**, or PNH:

- Soliris® (eculizumab), HCPCS code J1300
- Ultomiris® (ravulizumab-cwvz), HCPCS code J1303

Empaveli will continue to require prior authorization.

Here's other important information:

- Trial and failure of Vyvgart® or Vyvgart® Hytrulo and Rystiggo® is required for Soliris and Ultomiris for the diagnosis of **myasthenia gravis**. See this **Jan. 10, 2024, provider alert** for additional information.
- 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 drugs require prior authorization, as applicable, 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

How to access NovoLogix

To access NovoLogix, log in to our provider portal (**availity.com**), click on *Payer Spaces* in the menu bar and then click on the BCBSM and BCN logo. 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 medical benefits, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**.

We'll update this list before 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.

Hemlibra has a quantity limit requirement for most commercial members

We've added a quantity limit requirement for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for Hemlibra® (emicizumab-kxwh), HCPCS code J7170. The new quantity limit requirement, effective for dates of service on or after June 20, 2024, is in addition to the prior authorization and site-of-care requirements that apply to this drug when it's covered under the medical benefit.

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial 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**.

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

List of requirements

For a full list of quantity limit requirements related to drugs covered under the medical benefit, see the document titled **Blue Cross and BCN quantity limits for medical drugs**.

Requirements, 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 medical benefits. As part of this effort, we maintain comprehensive lists of requirements for our members.

In April, May and June 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.

Continued on following page

Changes in requirements

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

HCPCS code	Brand name	Generic name
J3590*	Beqvez™	Fidanacogene elaparvovec-dzkt
J3590*	Bkemv™ IV	Eculizumab-aeeb
J3590*	Hercessi™	Trastuzumab
J3590*	Opuviz™	Aflibercept-yszy
J3590*	Yesafili™	Aflibercept-jbvf

For Medicare Plus Blue℠ and BCN Advantage℠ members, we added prior authorization requirements for the following drugs:

HCPCS code	Brand name	Generic name	For dates of service on or after
J1599	Alyglo™	Immune globulin intravenous, human-stwk 10%	4/1/2024
J3590	Amtagvi™	Lifileucel	4/1/2024
J3590	Avzivi®	Bevacizumab-tnjn	4/1/2024
J1931	Ryzneuta®	Efbemalenograstim alfa-vuxw	4/1/2024
Q5111	Udenyca® Onbody	Pegfilgrastim-cbqv	4/1/2024
Q5133	Tofidence™	Tocilizumab-bavi	5/1/2024
J3590	Winrevair™	Sotatercept-csrk	5/1/2024
J3590	Beqvez	Fidanacogene elaparvovec-dzkt	6/1/2024

Code changes

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

New HCPCS code	Brand name	Generic name
J0177	Eylea® HD	Aflibercept
J0589	Daxxify®	Daxibotulinumtoxin A
J1203	Pombiliti™	Cipaglucosidase alfa-atga
J2782	Izervay™	Avacincaptad pegol
J9376	Veopoz™	Pozelimab-bbfg

Continued on following page

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, authorization requirements apply only to groups that participate in the standard commercial 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**. 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.

Vyjuvek has additional requirements for most commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network have updated the medical policy for Vyjuvek® (beremagene geperpavec-svdt). The requirements in the medical policy apply for most Blue Cross and BCN commercial members for dates of service on or after July 22, 2024.

In keeping with the updated medical policy, the following additional requirement must be met for treatment with Vyjuvek to be considered medically necessary:

- The prescriber must attest that the member is receiving and adherent to wound care interventions.

Continued on following page

- The member must not use Vyjuvek on the same wound in combination with other gene therapies for the treatment of dystrophic epidermolysis bullosa, or DEB.

To see the full list of requirements in the updated medical policy, go to the **Medical Policy Router Search** page, enter the name of the drug in the *Policy/Topic Keyword* field and press *Enter*.

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

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial 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**.

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

Additional information

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

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

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

We've changed how we cover brand-name Copaxone 40 mg, starting August 1

Starting Aug. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network changed how we cover brand-name Copaxone® (glatiramer acetate) 40 mg, a medication commonly used to treat relapsing forms of multiple sclerosis.

Members can continue to fill their prescription with generic glatiramer acetate (Copaxone®, Glatopa®).

A new prescription may be needed.

The following table summarizes the changes for members if they continue to fill their prescription with brand-name Copaxone® 40 mg.

Affected drug list or benefit plan	Change for brand-name Copaxone® 40 mg starting Aug. 1
• Custom Select Drug List • Preferred Drug List • Closed Benefit	Drug not covered (Member will be responsible for the entire cost of the prescription.)
• Custom Drug List • Clinical Drug List	Member may pay more (Higher cost share)

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

Guidelines for billing Avastin for Blue Cross and BCN commercial members

When submitting claims for Avastin® (bevacizumab), follow these guidelines:

Use	Member	HCPCS code to use
Intravitreal treatment	Blue Cross commercial	J3590
	BCN commercial	J9035 **Important**: Don't bill with modifier JZ. Billing with modifier JZ may lead to incorrect denials and longer-than-expected wait times for reimbursement.
Intravenous, or IV, infusions for oncology treatment	Blue Cross commercial	J9035
	BCN commercial	J9035

Note: When Avastin is used for intravitreal treatment:

- For many members, prior authorization isn't required for diagnoses associated with intraocular conditions.
- Avastin injections are an off-label use and require a smaller-than-normal dosage.

For more information about requirements related to Avastin and other drugs covered under the medical benefit, see these documents:

- **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**
- **Utilization management medical drug list for Blue Cross and Blue Shield Federal Employee Program® non-Medicare members**
- **Medical oncology prior authorization list for Blue Cross and BCN commercial members: Medications that require authorization by Carelon**

You can access these lists 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**

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**
- *Blue Cross and BCN is covering an additional vaccine,* **Page 12**

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.

CPT II codes

Here are some billing tips when submitting CPT II codes for office, lab or facility visits:

- The use of CPT category II codes decreases the administrative burden on practitioners and staff, decreases requests for members' medical records for review, and impacts performance in many quality measures including Controlling High Blood Pressure, Eye Exams for Patients with Diabetes, Glycemic Status Assessment for Patients with Diabetes and Transitions of Care: Medication Reconciliation.
- Automating your EMR to add CPT category II codes to claims is the most efficient way to close quality gaps.
- When billed on a claim, the CPT category II code is added to the procedure code field with a $0 charge. If your billing system drops non-revenue-generating codes, enter $0.01. Exception: Medicare Advantage plans reimburse $35 for *1111F.
- CPT category II codes can be billed alone if reported outside of a visit, using the date the service was performed.
- If the patient has a visit and a CPT category II service was reviewed during the visit, the date of the visit should be entered for the visit service code date of service and the date the CPT category II service was performed should be entered for the CPT category II code date of service.

For more information, see the *2024 NPI Series – CPT Category II Codes (PDF)*. Here's how to find it.

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources (Blue Cross and BCN)*.
5. Click *Member Care* on the menu bar and then click *Clinical Quality* and *Clinical Quality Overview*. The PDF is under the *Network Performance Improvement* section.

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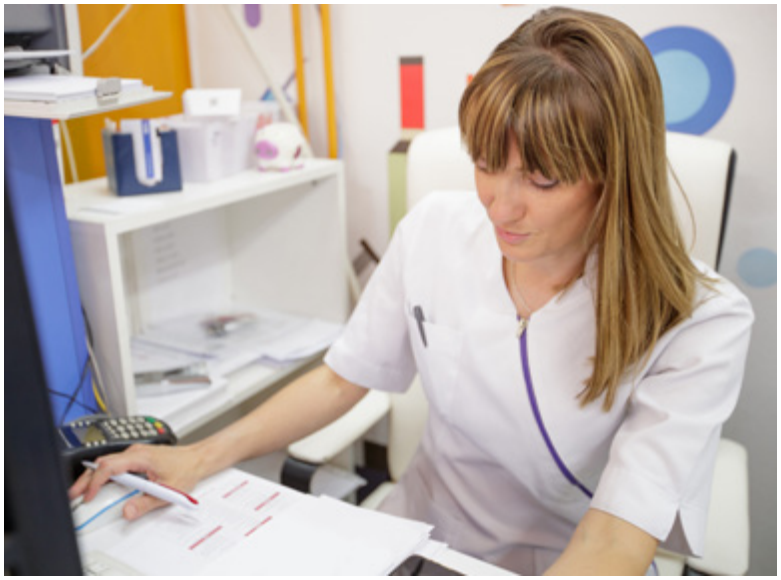


Billing Bulletin

BCN Provider *News*

Feedback

Clinical editing billing tips

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

This issue's tips:

- E&M when billed with preventive service
- Reporting and coding debridement codes

Clinical Editing Billing Tips

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

Changes to the *BCN referral and authorization requirements for Michigan providers* document

We updated the document titled *BCN referral and authorization requirements for Michigan providers*. Although the document continues to be accessible at the same location you're used to and at the same website address, we renamed it to **Michigan providers: BCN global referral, plan notification and prior authorization requirements** to reflect the full scope of the information found in the document. We also updated the look of the document and reorganized the information.

Here's a summary of the changes:

Section in previous document	Section in new document
"Section 1. Plan notification and authorization requirements" — Explanation of plan notifications and prior authorizations	Moved to the new "Overview of global referrals, plan notifications and prior authorizations" section. This section contains a detailed explanation of each of these terms.
"Section 1. Plan notification and authorization requirements" — Table of services	Replaced by the "Requirements at a glance" section. This section lists all services and indicates whether each service requires a global referral, plan notification or prior authorization. If more information is available for the service, the name of the service is linked. Clicking the link takes you to a subsection later in the document that includes the additional information.

Section in previous document	Section in new document
"Section 1. Plan notification and authorization requirements" — "Vendor contact information" subsection	Replaced by the "How to submit global referral requests, plan notifications and prior authorizations" section. This section states how to log in to our provider portal (availity.com) and access the appropriate portal for submitting global referral, plan notification and prior authorization requests.
"Section 2: Referral requirements" — General referral requirements and product-specific requirements	Moved to the new "Overview of global referrals, plan notifications and prior authorizations" section. Look in the "Global referrals" subsection.
"Section 2: Referral requirements" — Table of services	Moved into the new "Requirements at a glance" section.

You can access the updated document by:

1. Going to **ereferrals.bcbsm.com**.
2. Clicking *BCN*.
3. Clicking *Prior Authorization & Plan Notification* in the left navigation.
4. Clicking the *Michigan providers: BCN global referral, plan notification and prior authorization requirements* link.

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

Home health care services won't require prior authorization for Medicare Advantage members, starting Oct. 1

For dates of service on or after Oct. 1, 2024, home health care services for Medicare Plus Blue℠ and BCN Advantage℠ members won't require prior authorization.

For dates of service before Oct. 1, 2024, continue to submit prior authorization requests to CareCentrix® for our Medicare Advantage members.

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.

Watch for provider alerts and articles in *BCN Provider News* with additional information about this change.

CareCentrix is an independent company that manages the prior authorization of home health care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Updated TurningPoint medical policies for musculoskeletal and pain management procedures

Blue Cross Blue Shield of Michigan, Blue Care Network and TurningPoint Healthcare Solutions LLC are updating TurningPoint medical policies for musculoskeletal and pain management procedures. These policies apply to prior authorization requests submitted on or after Oct. 16, 2024.

The updated TurningPoint medical policies will be available in the TurningPoint provider portal on Oct. 16, 2024.

For details, see the document **2024 updates to TurningPoint medical policies for musculoskeletal and pain management procedures**.

Referral Roundup

Release schedule for eviCore category assignments and practitioner performance summaries for PTs and OTs

EviCore healthcare assigns physical and occupational therapists to a category that affects the information you need to supply when submitting prior authorization requests. You can view your category assignment through your practitioner performance summary.

When eviCore releases category assignments

EviCore releases practitioner performance summaries with updated categories twice a year. The category assignment from the report is effective two months following the release of the report.

Report is released	Category assignment is effective
First business day of **February**	First business day of **April**
First business day of **August**	First business day of **October**

Continued on following page

How to view practitioner performance summaries

As a reminder, eviCore no longer sends written notification of physical therapy utilization management category changes through postal mail. Instead, you can view practitioner performance summaries, which include your category assignment, through the eviCore provider portal. To do this:

1. Log in to Blue Cross and BCN's provider portal (**availity.com**).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *eviCore Provider Portal* tile in the Applications tab.
4. In the eviCore provider portal, select *Practitioner Performance Summary* from the main menu.
5. Select the health plan *(Blue Care Network)* and a provider. Only providers you've added to your eviCore web user account are available to select.
6. Click the *UM Category* tab.

The eviCore provider portal displays the results of the most recent claims analysis and the key performance benchmarks eviCore used to determine your category.

How to appeal a category B assignment

If you believe there were circumstances that adversely affected your category assignment, you can request reconsideration within 15 days from the date on which eviCore published the new practitioner performance summary.

Submit the request for category reconsideration through the Practitioner Performance Summary area of the eviCore provider portal.

Background

EviCore assigns physical and occupational therapists to a category based on physical therapy visits per episode. They do this by retroactively reviewing physical therapy claims from a one-year period. The categories are:

- **Category A**: When submitting prior authorization requests, providers need to submit limited information about the patient's condition. EviCore approves the request for a block of visits over an extended duration. The provider determines the number of visits that are medically necessary within the approved time period.
- **Category B**: When submitting prior authorization requests, providers need to submit additional information, which varies based on the patient's age and condition and the type of request (initial or continuing). The number of visits eviCore approves varies based on the patient's condition, severity, complexity and response to treatment received.

Important: For hospitals or outpatient therapy centers that bill both physical and occupational therapy using the same NPI, the assigned category establishes the review requirements for both physical and occupational therapists. This is true even though the category is based only on physical therapy claims and occupational therapists aren't assigned to a category.

Additional information

To learn more about category assignments and practitioner performance summaries, see the following documents:

- **Musculoskeletal Specialized Therapy Program: Physical Therapy Practitioner Performance Summary and Provider Category FAQs**
- **Practitioner Performance Summary and Utilization Management Categories**

The above documents are available on the **BCN PT, OT, ST and Physical Medicine Therapy Services** page on **ereferrals.bcbsm.com**.

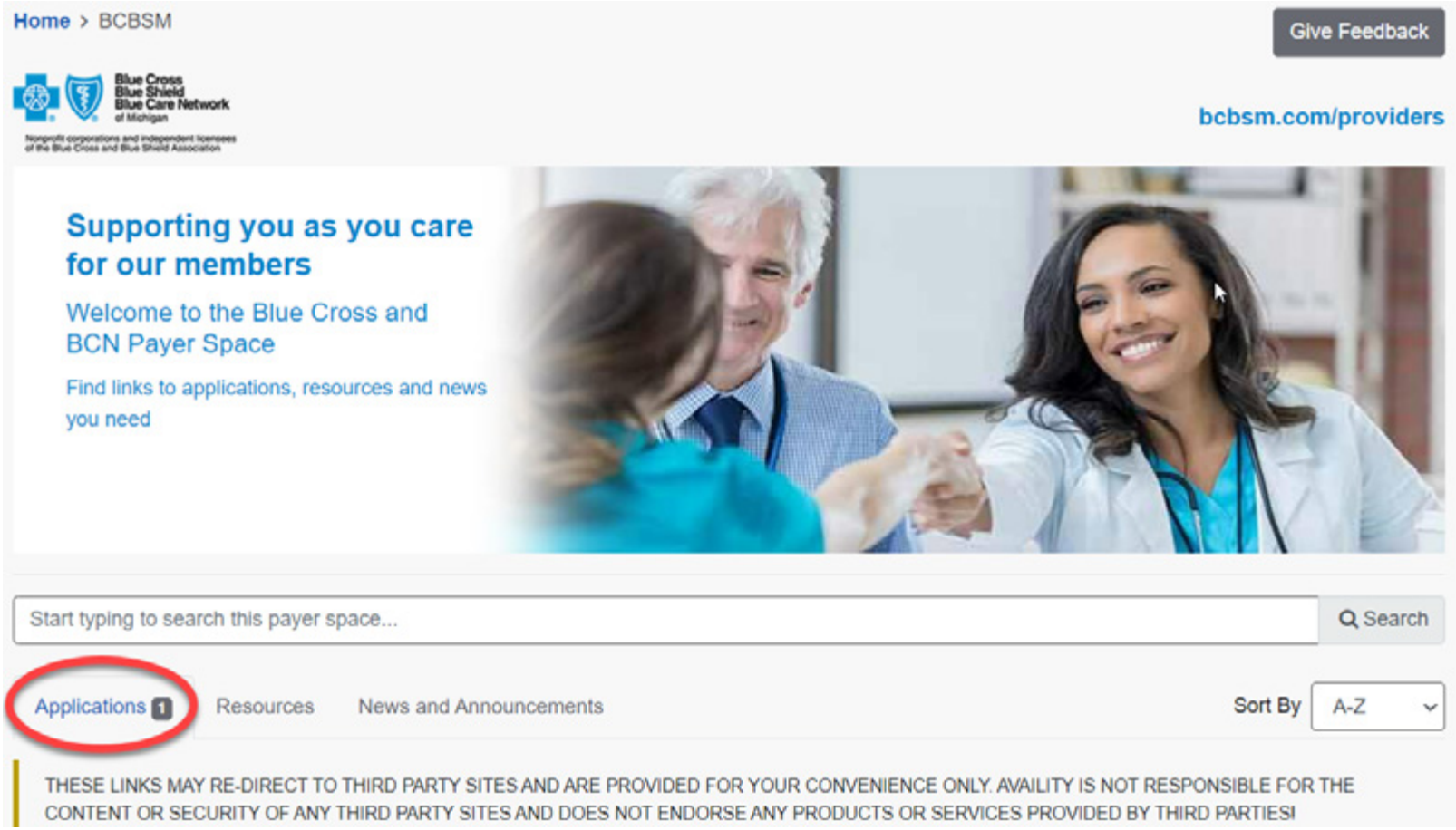
Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

eviCore healthcare 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.

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

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

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



Additional information available for providers

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

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

Questionnaire changes in the e-referral system

On May 26 and June 23, 2024, we updated and deleted questionnaires in the e-referral system. We also 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.

Updated questionnaires

On May 26 and June 23, we updated the following questionnaires:

Questionnaire	Opens for	Updates	Release date
Chemical peels, dermal	BCN commercial	• For BCN AdvantageSM, this questionnaire no longer opens. However, procedure codes *15789 and *15793 continue to require prior authorization for those members. • For BCN commercial, there are no changes to the questionnaire.	June 23, 2024
Chemical peels, epidermal	BCN commercial	• For BCN Advantage, this questionnaire no longer opens. However, procedure codes *15788 and *15792 continue to require prior authorization for those members. *17360 is no longer covered by Medicare or by our Medicare Advantage plans. • For BCN commercial, there are no changes to the questionnaire.	June 23, 2024
Enteral nutrition	BCN commercial	• For BCN Advantage, the questionnaire no longer opens. However, the following procedure codes continue to require prior authorization for those members: B4102, B4103, B4104, B4149, B4150, B4152, B4153, B4154, B4155, B4157, B4158, B4159, B4160, B4161, B4162, B9002 and B9998. • For BCN commercial, the questionnaire no longer opens for the following procedure codes: S9341, S9342 and S9343.	June 23, 2024
Hyperbaric oxygen therapy	BCN Advantage	Updated a question and added a question.	May 26, 2024
Hyperbaric oxygen therapy	BCN commercial	Updated a question.	May 26, 2024

Continued on following page

Deleted questionnaire

On May 26, we deleted the following questionnaire from the e-referral system:

Questionnaire	Updates
Medicare implantable ambulatory event monitors	This questionnaire no longer opens for Medicare Plus Blue℠ or BCN Advantage members. However, procedure code *33285 continues to require prior authorization for these members.

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time.

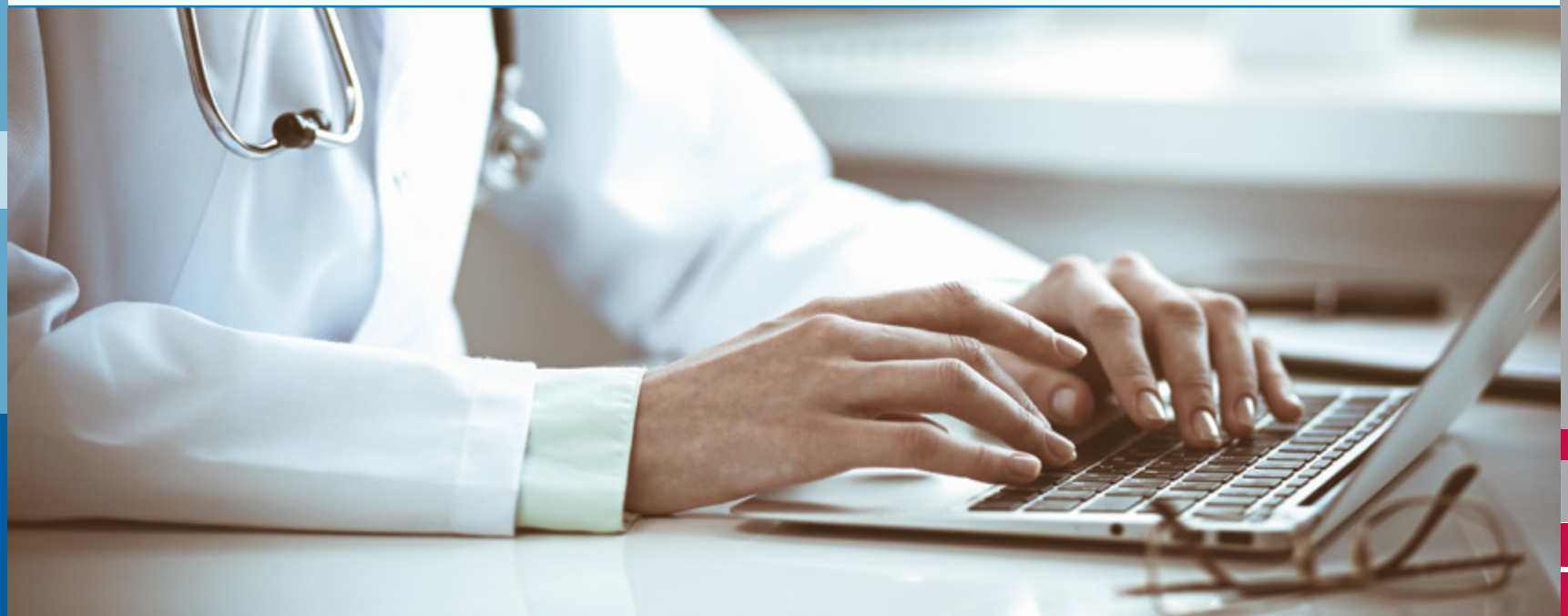
To find the preview questionnaires, see the document titled **Authorization criteria and preview questionnaires**.

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.

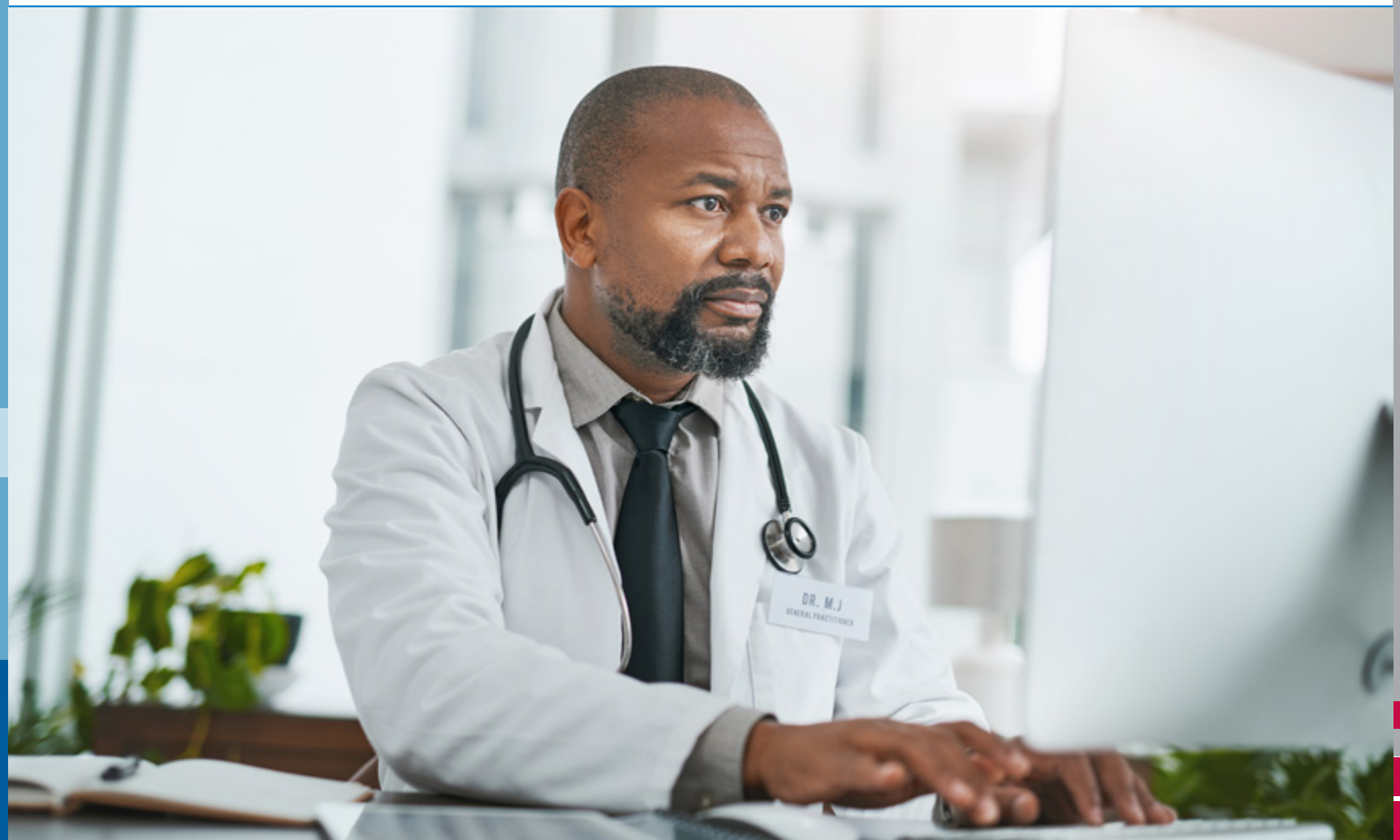
Authorization criteria and medical policies

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



Referral Roundup

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



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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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Feedback

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**.

Network Operations

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.

Network Operations

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.

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

- *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.

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.

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

- *Facilities and organizational providers must use the Provider Data Management tool within Availity Essentials to update and attest to information, starting Dec. 1,* **Page 4**
- *Webinars for physicians, coders focus on risk adjustment, coding,* **Page 6**
- *Close the gap in Statin Use in Persons with Diabetes measure,* **Page 13**
- *Our program to help reduce avoidable inpatient readmissions for Medicare Advantage members has changed,* **Page 14**
- *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**
- *Medicare Prescription Payment Plan available to help Medicare members manage drug expenses,* **Page 19**
- *Upcoming closures of Rite Aid, Walgreens retail pharmacies,* **Page 20**
- *Requirements and codes changed for some medical benefit drugs,* **Page 21**
- *Rituximab preferred agents to change for Medicare Advantage members, starting Jan. 1,* **Page 26**
- *Reminder: Home health care services no longer require prior authorization for Medicare Advantage members,* **Page 31**
- *Prior authorization changes for blepharoplasty, enteral nutrition, percutaneous left atrial appendage and varicose vein treatment,* **Page 32**
- *Learn more about changes related to post-acute care services for Medicare Advantage members,* **Page 34**

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.

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.

Continued on following page

Pharmacy News

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**

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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

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

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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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