JULY–AUGUST 2025

BCN Provider News

How to protect yourself from NPI-related fraud

Your national provider identifier, or NPI, is a unique number assigned to you as a health care provider to process claims and conduct other administrative tasks. But, because these identifiers are publicly available, they're at risk of being used in fraudulent schemes. Bad actors can obtain these NPIs from online directories or other public sources and use them to submit false claims or commit other types of health care fraud. This can lead to financial losses, damage to the provider's reputation and legal consequences. It's essential for providers to be aware of this risk and take steps to monitor their claims and billing statements for any suspicious activity.

To protect yourself from NPI-related fraud, it's crucial to be vigilant and proactive.

- Monitor your claims and billing statements regularly for any unusual or unauthorized activity. If you suspect that your NPI has been used in a fraudulent scheme, act quickly.
- Report the incident to the Centers for Medicare & Medicaid Services using its **online reporting tool**.
- Notify your billing and insurance companies, as well as your state medical board, to prevent further fraudulent activity.

By taking these steps, you can help protect your practice and prevent financial losses due to NPI theft. And reporting any suspicious activity can help prevent further harm to your practice and reputation.

Our organization recently encountered a real-life example of NPI theft. We received an influx of durable medical equipment claims with rendering provider NPIs. Many of the providers contacted during the verification process said they had no knowledge of the patients related to those claims and suspected their NPIs had been used without their consent. If we had not reached out to the providers, they may have remained unaware that their NPIs were being used for fraudulent activity. This highlights the importance of vigilance and proactive monitoring to detect and prevent NPI theft. By working together, we can help prevent these types of scams and protect the integrity of the health care system. If you suspect that your NPI has been compromised, report it to CMS and take steps to protect your practice and reputation.

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Feedback

BCN updates fee schedules July 1

Effective July 1, 2025, Blue Care Network is updating its BCN commercial fee schedules.

BCN 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*.

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

Here's an overview of Identification of Microorganisms Using Nucleic Acid Probes policy

The use of nucleic acid testing using either single pathogens or panel testing is established in specified situations for Blue Cross Blue Shield of Michigan and Blue Care Network commercial. It may be considered a useful diagnostic tool when indicated. The updated criteria effective Jan. 1, 2025, is outlined below.

Inclusionary and exclusionary guidelines

The status of nucleic acid identification (using either direct probe, amplified probe or quantification) for certain microorganisms are summarized in the table below by CPT code (if applies) and status of the procedure (established or investigational).

Note: In the table, EST is an abbreviation for established and INV for investigational.

Determination table for microorganism by test, CPT code (if applies) and efficacy				
Microorganism	**Direct Probe**	**Amplified Probe**	**Quantification**	**Other Techniques**
Bartonella henselae or quintana	EST	87471 - EST	87472 - INV	N/A
Candida species – non-vaginal	87480 – EST	87481 - EST	87482 - INV	N/A
Central nervous system pathogen panel[a]	EST	87483 - EST	EST	N/A
Chlamydia pneumoniae	87485 - EST	87486 - EST	87487 - INV	N/A
Clostridium difficile	EST	87493 - EST	INV	N/A
Cytomegalovirus	87495 - EST	87496 - EST	87497 - EST	N/A

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Enterococcus, vancomycin-resistant	EST	87500 - EST	INV	N/A
Enterovirus	EST	87498 - EST	INV	N/A
Gastrointestinal pathogen panel	INV	87505, 87506 EST 87507 - INV	INV	N/A
Hepatitis B	EST	87516 - EST	87517 - EST	N/A
Hepatitis C	87520 - EST	87521 - EST	87522 - EST	N/A
Hepatitis D	NA	N/A	87523 – EST	N/A
Hepatitis G	87525 - INV	87526 - INV	87527 - INV	N/A
Herpes virus 6	87531 - EST	87532 - EST	87533 - EST	N/A
Human papillomavirus	EST	EST	INV	87623-87625 EST
Influenza virus	EST	87501-87503 - EST	EST	N/A
Legionella pneumophila	87540 - EST	87541 - EST	87542 - INV	N/A
Mycobacterium species	87550 - EST	87551 - EST	87552 - INV	N/A
Mycobacterium tuberculosis	87555 - EST	87556 - EST	87557 - INV	N/A
Mycobacterium avium intracellulare	87560 - EST	87561 - EST	87562 - INV	N/A
Mycoplasma pneumoniae	87580 - EST	87581 - EST	87582 - INV	N/A
Papillomavirus	87623-87625 - EST	87623-87625 - EST	INV	N/A
Respiratory syncytial virus (RSV)	N/A	87634 - EST	N/A	N/A
Respiratory virus panel	EST	87631-87633 - EST	INV	N/A
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)[b]	N/A	87635 - EST	N/A	N/A
Sexually Transmitted Diseases				
• Chlamydia trachomatis	87490 – EST	87491 - EST	87492 – INV	N/A
• Herpes Simplex Virus	87528 - EST	87529 – EST	87530 – INV	N/A
• HIV 1	87534 - EST	87535 - EST	87536 - EST	N/A
• HIV 2	87537 - EST	87538 - EST	87539 - EST	N/A
• Mycoplasma Genitalium	N/A	87563 - EST	N/A	N/A
• Neisseria gonorrhoeae	87590 - EST	87591 - EST	87592 - INV	N/A
Staphylococcus aureus	EST	87640 - EST	INV	N/A
Staphylococcus aureus, methicillin-resistant	EST	87641 - EST	INV	N/A

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Streptococcus, group A	87650 - EST	87651 - EST	87652 - INV	N/A
Streptococcus, group B	EST	87653 - EST	INV	N/A
Urinary tract infections[a]	EST	EST	INV	N/A
Zika virus	EST	87662 - EST	INV	N/A

[a] Considered established when criteria below are met.

[b] This medical policy doesn't address antibody testing (serological IgG assays).

Panel testing using nucleic acid probes for **central nervous system** pathogens are considered established when **one** of the following criteria is met:

- As an adjunct to standard work-up with cerebral spinal fluid, or CSF, culture and sensitivity, and other epidemiologic and laboratory data
- The individual has clinical findings consistent with a central nervous system infection (for example, meningitis, encephalitis)
- Viral etiology is suspected, or CSF culture is inconclusive for a pathogen (for example, viral, bacterial fungal, yeast)

Repeat panel testing for the same clinical indication will only be covered when **all** the following are met:

- First panel yielded a negative result
- There is a high index of suspicion for a pathogen as the cause of symptoms
- The individual's clinical condition is not improving or is deteriorating after a clinically appropriate length of time

Single nucleic acid probe testing for urinary tract pathogens to diagnose an infection (for example, prostatitis, urinary tract infection) is considered established when **all** the following are met:

- Documentation includes proper technique for urine specimen collection (such as clean catch, straight catheter)
- Urinary tract symptoms (such as dysuria, frequency, urgency) remain after treatment with two courses of antibiotics based on results of urine culture and sensitivity
- The individual has a current immunocompromised[a] condition or has post-surgical abnormal genital urinary tract anatomy

Note: Criteria for single nucleic acid probe testing for urinary tract pathogens is established for covered organisms without a specific CPT code and up to 10 units/pathogens in infection diagnoses (for example, prostatitis, UTI).

Polymerase chain reaction, or PCR, testing for the following microorganisms that don't have specific CPT codes are considered established:

- Actinomyces, for identification of actinomyces species in tissue specimens
- Adenovirus, to diagnose **any** of the following:
  - Adenovirus myocarditis
  - Adenovirus infection in immunocompromised[a] hosts, including transplant recipients
- Avian influenza A virus, for diagnosis of avian influenza A (H5N1) in people with **both**:
  - Symptoms consistent with Avian influenza A virus
  - A history of travel to or contact with people or birds from a country with documented H5N1 avian influenza infections within 10 days of symptoms onset
- Bacillus anthracis
- BK polymavirus in transplant recipients receiving immunosuppressive therapies and people with immunosuppressive disease[a]
- Bordetella pertussis and B. parapertussis, for diagnosis of whooping cough in individuals with coughing

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Network Operations

- Brucella spp., for members with signs and symptoms of brucellosis, and history of direct contact with infected animals and their carcasses or secretions or by ingesting unpasteurized milk or milk products
- Burkholderia infections (including B. cepacian, B. gladioli)
- Chancroid (haemophilus ducreyi), for diagnosis of persons with genital ulcer disease
- Clostridium difficile
- Coxiella burnetiid (Q fever)
- Dengue virus
- Epidemic typhus (Rickettsia prowazekii)
- Epstein Barr virus, or EBV, for detection of EBV in post-transplant lymphoproliferative disorder; or for testing for EBV in people with lymphoma; or for those who are immunocompromised[a] for other reasons
- Francisella tularensis, for presumptive diagnosis of tularemia
- Hantavirus, diagnosis
- Hemorrhagic fevers and related syndromes caused by viruses of the family bunyaviridae (Rift Valley fever, Crimean-Congo hemorrhagic fever, hemorrhagic fever with renal syndromes), for diagnosis in acute phase in people with clinical presentation suggestive of these conditions
- Hepatitis E virus, or HEV, for definitive diagnosis in persons with anti-HEV antibodies
- Human metapneumovirus
- Human T lymphotropic virus type 1 and type 2 (HTLV-1 and HTLV-2), to confirm the presence of HTLV-1 and HTLV-2 in the cerebrospinal fluid of people with signs or symptoms of HTLV-1/HTLV-2
- JC polyomavirus, in transplant recipients receiving immunosuppressive therapies, in persons with immunosuppressive diseases[a], and for diagnosing progressive multifocal leukoencephalopathy in persons with multiple sclerosis or Crohn's disease receiving natalizumab (Tysabri)
- Leishmania
- Measles virus (morbilliviruses, rubeola), for diagnosis of measles
- Mumps
- Neisseria meningitis, to establish diagnosis where antibiotics have been started before cultures have been obtained
- Parvovirus, for detecting chronic infection in immunocompromiseda people
- Psittacosis, for diagnosis of chlamydophila (chlamydia) psittaci infection
- Rubella, diagnosis
- Severe acute respiratory syndrome, or SARS, for detection of SARS coronavirus RNA in people with signs or symptoms of SARS who have traveled to endemic areas or have been exposed to people with SARS
- Toxoplasma gondii, for detection of T. gondii infection in immunocompromised[a] people with signs and symptoms of toxoplasmosis, and for detection of congenital Toxoplasmagondii infection (including testing of amniotic fluid for toxoplasma infection)
- Varicella-Zoster infections
- Whipple's disease (T. whippeli), biopsy tissue from small bowel, abdominal or peripheral lymph nodes, or other organs of persons with signs and symptoms, to establish the diagnosis
- Yersinia pestis

[a] Immunocompromised individuals consist of those with weakened immune systems including human immunodeficiency virus or acquired immunodeficiency syndrome, individuals who are taking immunosuppressive medications (such as chemotherapy, biologics, transplant-related immunosuppressive drugs, high-dose systemic corticosteroids) and those with inherited diseases that affect the immune system (such as congenital immunoglobulin deficiencies).

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Exclusions:

- The use of nucleic acid testing with direct or amplified probes for Hepatitis G microorganisms
- Direct probe, amplified probe or panel testing of pathogens used for the diagnosis of an uncomplicated urinary tract infection
- Any nucleic acid panel or single pathogen testing for any of the following conditions:
  - Wound infection
  - Blood stream infection/sepsis

  Exception: When criteria above are met for meningitis.
- Testing that is performed as a test of cure
- Molecular-based panel testing for general screening of microorganisms (for example, MicroGenDX qPCR+ NGS)
- Any nucleic acid or PCR testing that isn't FDA approved or identified above as established

None of the information included in this article is intended to be legal advice and, as such, it remains the provider's responsibility to ensure that all coding and documentation are done in accordance with all applicable state and federal laws and regulations.

On-demand opportunities are available for provider training

Action item

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

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

The following learning opportunities are now available:

- **e-referral mini module: Submitting an inpatient authorization**

  This is a revised interactive mini module in the series on using e-referral to submit prior authorization requests. The new format is based on an interactive system simulation, where you will learn the basics of submitting an inpatient authorization. The hands-on module only takes about 6 minutes to complete.

- **CMS Star and HEDIS® measures mini modules**

  Prior eLearning courses on Star and HEDIS measures are now broken down into mini modules. You can learn about the measures in just a few minutes each. Search *Star* or *HEDIS* to see the list of available topics. The mini modules have all the updates from the 2025 technical specifications.

Continued on following page

How to access provider training resources

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.

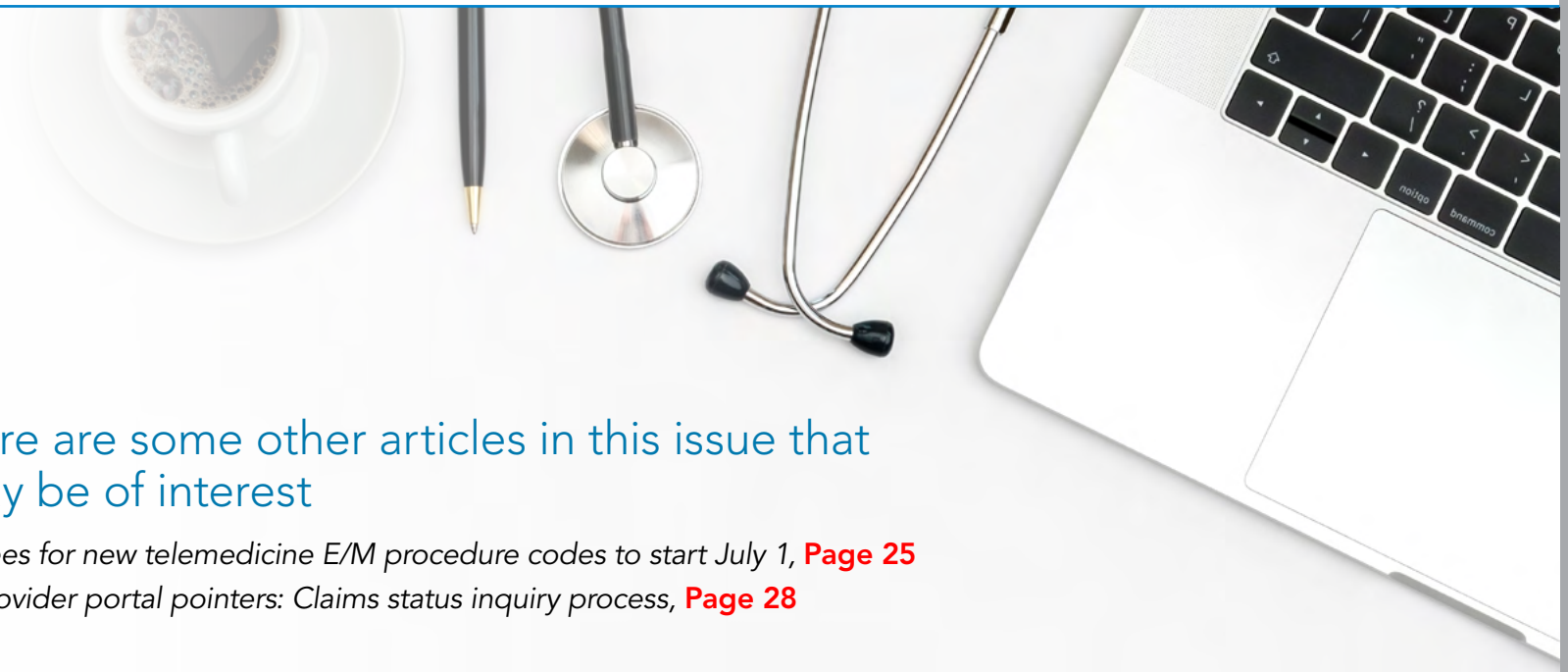
Existing users who used the same email address as their provider portal profile email will be directed to the training site. If you used a different email address, contact **ProviderTraining@bcbsm.com** to update your profile.

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**.

HEDIS is also known as the Healthcare Effectiveness Data and Information Set. HEDIS® is a registered trademark of the National Committee for Quality Assurance.



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

- *Fees for new telemedicine E/M procedure codes to start July 1,* **Page 25**
- *Provider portal pointers: Claims status inquiry process,* **Page 28**

BCN Advantage

Complete Continuity of Care Guideline in e-referral system for some Medicare Advantage members

For select Medicare Plus Blue℠ and BCN Advantage℠ members who are eligible for continuity of care arrangements, health care providers need to provide additional information in the e-referral system. This started April 3, 2025.

When will the questionnaire open?

Providers need to respond to the Continuity of Care Guideline when submitting prior authorization requests for:

- New Medicare Plus Blue or BCN Advantage members who require an ongoing course of treatment.
- Members who move from a Medicare Plus Blue plan to a BCN Advantage plan or vice versa.

What information will be requested?

Providers will have to indicate whether:

- The member has an active prior authorization from another health plan.
- The procedure was discussed with the member and decided upon before the member's enrollment date.

Providers will also have to attest that:

- The member's care request is part of an active course of treatment and meets the Medicare requirements.
- The prior authorization request is for a continued course of treatment and is medically reasonable and necessary to avoid disruptions in care.

BCN Advantage

Select Medicare Advantage members will receive Cologuard test kits in July

Blue Cross Blue Shield of Michigan and Blue Care Network are working with Exact Sciences, a credentialed colorectal cancer screening provider, to distribute in-home Cologuard® test kits in July to select Medicare Plus Blue℠ and BCN Advantage℠ members.

Health care providers with patients who receive an advance notice about the kits 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 Cologuard screening kits. Members who received kits from a Blue Cross or BCN program in 2023 or 2024, or are due for a colonoscopy in 2025, are excluded. Members will be encouraged to discuss test results with their primary care providers.

Test result notification

	Results	Positive results
Blue Cross or BCN Medicare Advantage member	• Letter including member's results (negative only) • Text message and email, if member provides contact information, notifying member results are ready • Members can contact Exact Sciences Patient Support Line 24/7	• Certified letter for all members who received positive results • Up to three phone call attempts to notify member of positive result • If unable to contact member by phone, results will be mailed a second time by standard mail
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 **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.

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

Patient Care/ Quality

Enhancing care for seniors on-demand webinar series: Improving health outcomes for older adults

What you need to know

A three-part, on-demand webinar series is available that focuses on navigating sensitive topics with senior patients.

As physicians, you strive to deliver high-quality, patient-centered care to your senior patients. However, navigating sensitive topics and addressing unmet health concerns can be a significant challenge. To support you in this endeavor, we are excited to introduce an on-demand webinar series designed specifically for providers and their clinical staff.

This three-part series focuses on practical strategies for discussing sensitive topics with seniors, such as mental health, urinary incontinence, fall risk and physical activity. You will learn how to initiate and navigate these conversations with empathy and understanding, building trust and fostering open communication with your patients.

For Patient-Centered Medical Home (PCMH) designated practices, this series supports **PCMH capabilities 9.13** (screening for fall risk and physical activity) and **9.14** (screening for bladder control).

Continued on following page

Here is a brief breakdown of each webinar part:

- **Part 1: Ensuring effective care through conversations**

  The first part of the series focuses on the importance of bringing up sensitive topics with patients, along with a brief overview of the Health Outcomes Survey (HOS).

  - Tips for navigating discussions around urinary incontinence, physical activity and fall risk
  - How HOS is used by CMS to assess the health status of seniors over time

- **Part 2: Discussions to help older patients maintain or improve their mental and physical health**

  The second part of the series focuses on the risks of poor physical and mental health for older adults.

  - Strategies to discuss physical health and mental health
  - Use of patient-centered planning to improve or maintain patients' health

- **Part 3: Overcoming barriers to sensitive conversations with patients**

  The final part of the series analyzes both patient and provider anxiety around discussing sensitive topics like those mentioned in Parts 1 and 2.

  - Tips to alleviate some of the anxiety and discomfort of discussing sensitive topics
  - How to prepare for having sensitive conversations with patients

To access the patient experience library of content, log in to the provider training homepage through our provider portal:

1. Log in to **availity.com**.
2. Click on *Payer Space* in the top menu bar, and then click on the BCBSM and BCN logo.
3. Click on the *Applications* tab
4. Scroll down to the *Provider Training Site* tile and click on it.
5. Click on *Course Catalog* once you are on the training site and select *Patient Experience* on the left. You can also search for "px," "patient experience" or by session name.

If you don't have access to Availity, you can directly log in to the **training website**. You can also check out courses on other topics while you're browsing.

If you have questions about the provider training website, email **ProviderTraining@bcbsm.com**.

Medical assistants and other health care professionals can earn **continuing education credits** with a certificate of completion. Physicians are eligible for **continuing medical education credits** upon successful completion of these courses and many other patient experience courses. We appreciate all you do to enhance the patient experience and are excited to support you in further developing your skills and expertise. For information, email **PatientExperience@bcbsm.com**.

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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.

Medication adherence and medication review

Remind patients to bring their medications to each visit by adding messaging to appointment reminders. During the visit, 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.

Cost, side effects and barriers to pharmacy pickup 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.

The 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 **availity.com**.
2. Click on *Payer Space* in the top menu bar, and then click on the BCBSM and BCN logo.
3. Click on 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*.
3. Scroll to "Looking for medical policies?" and click Search *medical policies*.

Recent updates to the medical policies include:

Covered services

- Analysis of human FIT-DNA (i.e., Cologuard®) and FIT-RNA (i.e., Colosense®) in stool samples as a technique for colorectal cancer screening
- Bariatric surgery (gastric surgery for morbid obesity)
- Bone marrow transplant – Hematopoietic cell transplant for genetic diseases and acquired anemias, allogeneic
- Cosmetic and reconstructive surgery
- Diagnosis of sleep disorders
- Drug coated balloon for urethral strictures (i.e., Optilume urethral drug coated balloon)
- Genetic testing – Malignant gliomas including MGMT promoter methylation
- Nonthermal histotripsy (i.e., Edison System) for primary and metastatic liver tumors
- Obstructive sleep apnea – non-surgical treatment
- Obstructive sleep apnea and snoring – surgical treatment
- Panniculectomy
- Peripheral nerve injury repair using synthetic conduits or processed nerve allografts
- Screening for lung cancer and pulmonary nodule evaluation using low dose computed tomography (CT) scanning, computer aided detection (CAD) or chest radiographs
- Transcutaneous electrical nerve stimulation (e.g., Cefaly®, eTNS, Axon) and transcutaneous afferent patterned stimulation (e.g., Cala One™, Cala TRIO™, Cala klQ)

Noncovered services

- Genetic testing for pharmacogenetic pain management
- Handheld radiofrequency spectroscopy and computer-aided fluorescence imaging during breast-conserving surgery (e.g., MarginProbe, LumiSystem)
- Headaches – Nerve blocks / Ganglion blocks
- Implantable peripheral nerve stimulation and peripheral subcutaneous field stimulation devices for the treatment of chronic pain
- Magnetic Pelvic Floor Stimulation / Flyte System as a treatment of urinary incontinence

Established

- Autism Spectrum Disorder services
- Enteral nutrition
- GT-NGS
- Magnetic Resonance Imaging of the breast
- Telemedicine services
- Total parenteral nutrition

Experimental/Investigational

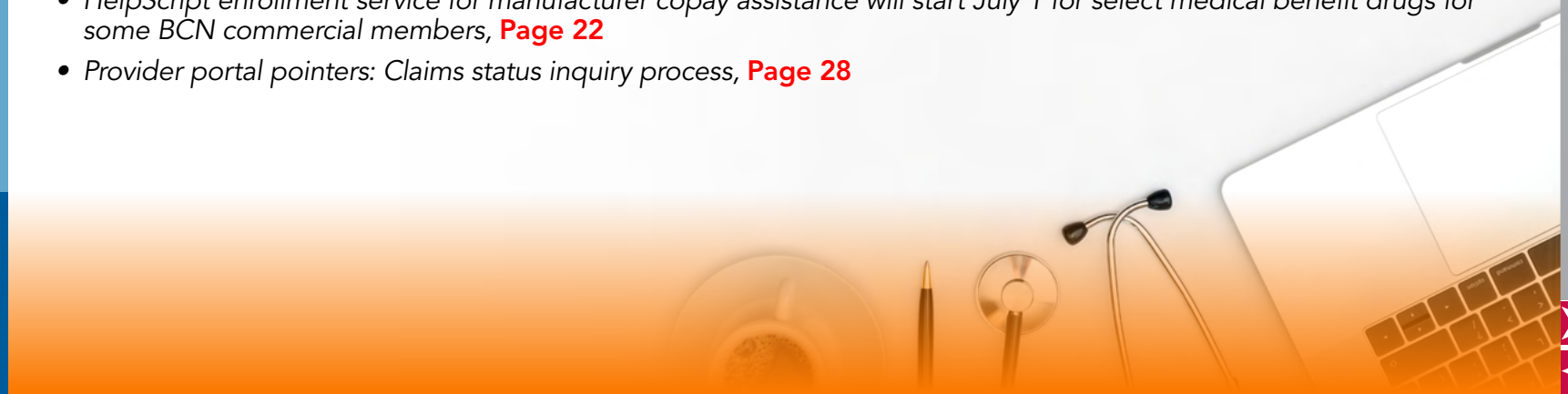
- Digital health technologies: Therapeutic applications
- Percutaneous Electrical Nerve Stimulation (PENS), Percutaneous Neuromodulation Therapy (PNT), and restorative neurostimulation therapy
- Platelet rich plasma autologous platelet – Derived growth factors as a treatment of wound healing and other non-orthopedic conditions

Mixed

- Low-level laser and high-power laser therapy
- Vagus nerve stimulation
- Wireless capsule endoscopy for GI disorders

Medical Policy Updates

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



Behavioral Health

BCN Provider *News*
Feedback

From the medical director

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

The science behind an autism diagnosis and its treatment is changing very rapidly, which is a good thing for our members. Based on collateral research on precision psychiatry and neuroscience, this column explores the current, predominant hypothesis of the etiology of autism.

Presenting a synopsis of the current thinking around autism etiology and treatment

We've known for many years that neonates, when born, have an overabundance of neurons and neural junctions in the brain — the most that they will ever have in their lives. Autistic children have even more, although the reason is currently unknown. We also know that the major neural pathways that link parts of the brain start out with a variable density of these neurons and junctions. When mapped to areas of the brain that mitigate and drive the symptoms of autism we see, they directly relate to those symptoms.

For example, the pathway to the Fusiform Gyrus (occipital lobe), which is related to facial recognition, is hypoactive in some autistic individuals, contributing to social difficulties interacting with others, especially strangers. Other connections and pathways such as the pathway

Continued on following page

to the temporal parietal lobe (which is linked to social cognition) is dysfunctional with many individuals as well as the path to the orbital frontal cortex, which has a role in social behavioral as well. Having poor function in these areas at the same time then drives the social difficulties many individuals exhibit.

These pathways may have either too many or not enough neurons and neural connections. If the pathway has too many, the behaviors mitigated by that pathway are accentuated. Those with not enough are deficit in the behaviors controlled by those areas of the brain. I have only provided three pathways involved in common behavioral symptomology, but there are other pathways involved as well. The observed behaviors and symptoms are a combination of the variable factors in multiple pathways and modify each other due to feedback loops in the brain.

The way the brain works then is to naturally "prune" the excess neurons in pathways where there is too much activity and not change or modestly "grow" additional neurons and junctions in pathways that do not have enough activity. This process is referred to as the brain being "plastic" and having over time the ability to strengthen weak pathways and slow down ones that are too active. This "plasticity" is more pronounced in younger children and decreases over the lifespan.

This is where Applied Behavior Analysis, known as ABA, comes in. As a combination of learning theory and behavior modification, ABA works by increasing the strength of the pathways, which will then improve (as much as possible) the behaviors that are a deficit for the individual. The other pathways that are too active can be slowed by not giving positive reinforcement for the negative behaviors that are desired to be "extinguished" or "mitigated." Both processes are a natural occurrence of pruning of the excess neurons and not decreasing or slightly increasing the neurons in the hypoactive pathways.

This is like habit modification and learning in general. You practice things you want to remember, which results in having faster recall. Those things you want to forget or habits you want to lose aren't rewarded. It takes much longer to extinguish a habit or behavior than learn a new one. The key to successful change, though, is consistent and repetitive reward for positive change and no reward for negative attributes. This is where working in a team with clear communication of even minute changes is important for all people who interact with the individual.

Once the behaviors have been brought to their best ability, there needs to be a period of trial and error with less frequent rewards to capitalize on the gains made to the process outlined above.

This combination of the science behind the process and improving the consistency in the process offers significant hope for improvement in function to the best of that individual's capacity.

References

- NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health. Grabrucker AM, editor. Autism Spectrum Disorders [Internet]. Brisbane (AU): Exon Publications; 2021 Aug20. doi: 10.36255/exonpublications.autismspectrumdisorders.2021. diagnosis **Chapter 2 Autism Spectrum Disorders: Diagnosis and Treatment** Ronan Lordan, Cristiano Storni, and Chiara Alessia De Benedictis.
- Determining Associations Between Intervention Amount and Outcomes for Young Autistic Children a Meta-Analysis. Micheal Sandbank, PhD; James E. Pustejovsky, PhD; Kristen Bottema-Beutel, PhD; Nicolette Caldwell, PhD; Jacob I. Feldman, PhD; Shannon Crowley LaPoint, PhD; TiffanyWoynaroski, PhD, CCC-SLP
- Neurodevelopmental Hypothesis about the Etiology of Autism Spectrum Disorders Toshio Inui 1 *, Shinichiro Kumagaya2 and Masako Myowa-Yamakoshi 3 1Department of Psychology, Otemon Gakuin University, Osaka, Japan, 2Research Center for Advanced Science and Technology, The University of Tokyo, Tokyo, Japan, 3Graduate School of Education, Kyoto University, Kyoto, Japan Huttenlocher, P.R.
- **Synaptic density in human frontal cortex - developmental changes and effects of aging** Brain Res. 1979; 163:195-205 **Children with Autism Have Extra Synapses in Brain | Columbia University Irving Medical Center**

Behavioral Health

Behavioral health providers shouldn't submit claims for behavioral health collaborative care services

As a reminder, behavioral health providers shouldn't bill Blue Cross Blue Shield of Michigan or Blue Care Network for collaborative care services performed in a primary care or specialty setting. These services are associated with:

- Procedure codes *99492, *99493 and *99494
- HCPCS codes G0512 and G2214

Claims submitted by behavioral health providers for these services will deny. These codes aren't payable for behavioral health providers.

Collaborative care services are covered under the member's medical benefits and must be billed by the member's treating medical provider.

Suicide prevention resources available for assessing at-risk patients

Blue Cross Blue Shield of Michigan supports the **Zero Suicide Initiative**, a **Collaborative Quality Initiative** supporting suicide prevention across Michigan.

If a behavioral health screening indicates that a patient has risk factors for attempting suicide, the current standard of care is to assess the patient's intent and risk.

We've compiled best practices that all medical care and behavioral health providers should incorporate into the assessments of their patients.

Resources for outpatient providers

The most common and established screening tool for depression is the **Patient Health Questionnaire-9**. This questionnaire asks patients about depression symptoms they may have experienced in the previous two weeks.

Question No. 9 asks patients if they've had "thoughts that you would be better off dead, or of hurting yourself." **If a patient responds with an affirmative answer to that question, then an additional assessment should be conducted. A provider can use a tool such as Ask Suicide-Screening Questions.**

If a screening indicates that a patient has a significant risk of suicidal ideation, the provider should complete the Columbia-Suicide Severity Rating Scale for **adults** or **children or adolescents**. It's a precise and valid method that helps determine suicide risk factors to discuss with family members or other supporters of the patient.

Recognizing warning signs is a reasonable step to assess and protect patients from harm. Examples of warning signs are a patient's history of previous suicide attempts, the specificity of a patient's intent and plan, and the availability of lethal means (ideation, method, access and intent).

Based on the assessment, here are options for interventions:

- Helping the patient use coping strategies

- Enlisting social support, such as family and friends, to help distract from suicidal thoughts and resolve the crisis
- Contacting behavioral health specialists for consultation and treatment
- Taking steps to make the patient's environment safe, such as having family or friends remove items from a patient's home if those items could be used to attempt suicide

If providers don't feel comfortable with or aren't trained in performing these interventions, they should refer the patient to a mobile crisis team that can see him or her immediately. Mobile crisis teams can visit patients wherever they may be – in their provider's office, a school or work setting, their home or anywhere else.

More information, including a list of behavioral health specialists and contact information, can be found at the **Behavioral Health Crisis Care** site.

The **National Action Alliance for Suicide Prevention** has a host of resources to assist providers in assessing and helping maintain patient safety in the face of suicidal ideation. Its summary report and recommendations for outpatient behavioral health, emergency room and primary care settings can be found **here**.

The Collaborative Care Model includes behavioral health specialists, such as a psychiatric consultant and behavioral health case manager, to assist medical practices in improving the mental health of their patients.

Continued on following page

Behavioral Health

Training and incentives are available to practices that register to become Collaborative Care practices. Behavioral health specialists who are part of the medical team — and assist the practice in treating behavioral health conditions — add backup and depth to the practice. These providers address situations with patients who are contemplating suicide and can provide expert direction in safely triaging or treating them.

Primary care or obstetric/gynecologic practices interested in joining the Collaborative Care initiative, should contact their physician organization for more information. Other questions can be directed to **valuepartnerships@bcbsm.com**.

Note: If providers encounter patients who present an imminent risk of harm to themselves or others, it's their professional and legal responsibility to take appropriate steps to help ensure their safety. The steps include notifying family, and law enforcement if appropriate, to assist the patient in getting mental health treatment.

Table 2 of **this American Family Physician article** has a list of questions that can help outpatient providers assess suicidal intent and risk.

Resources for inpatient providers

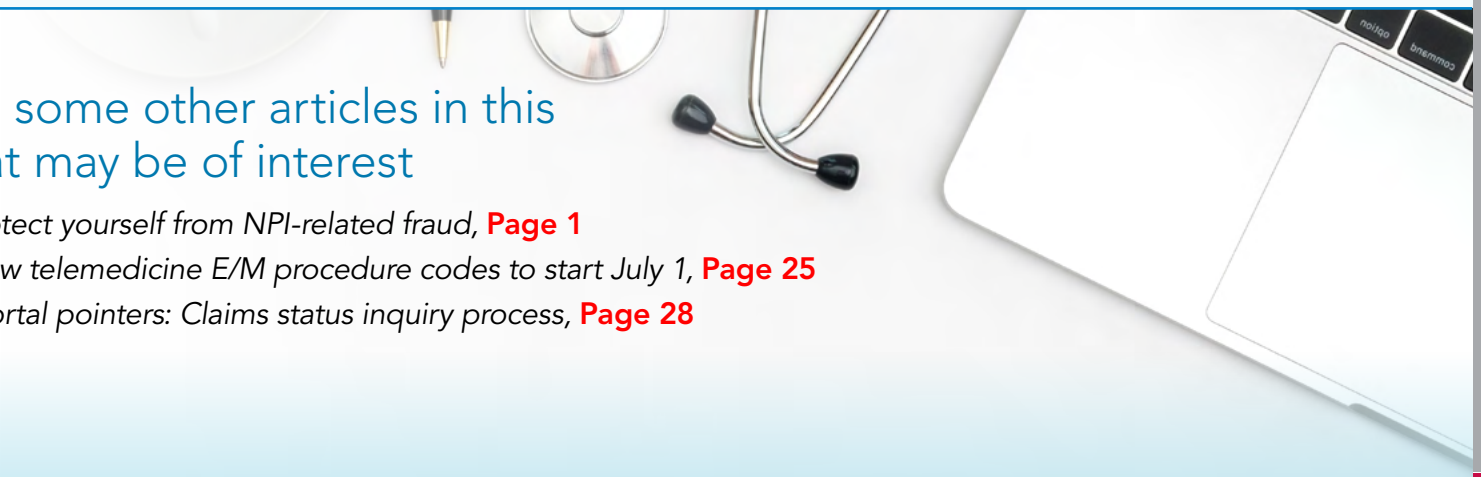
The Columbia-Suicide Severity Rating Scale serves multiple functions for inpatient behavioral health providers. It should be routinely administered for both internal and external documentation requirements.

For inpatient behavioral health providers, using the scale for **adults** or **children or adolescents** serves several purposes:

- Detailed assessment of suicide risks at admission for treatment planning
- On-going assessment or reassessment of risk during a patient's stay
- Evidence that the treatment intervention is effective
- Helpful resource that can be used to identify and mitigate risk factors during discharge planning:
  - Provision of contingency management options, including psychiatric urgent care, mobile crisis and crisis stabilization resources in the patient's community
  - Consideration of a behavioral health advance directive prior to discharge
- A standard of care assessment tool for purposes of documentation and risk management
- Communication of the risk assessment to providers accepting the transfer of care going forward

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

- *How to protect yourself from NPI-related fraud,* **Page 1**
- *Fees for new telemedicine E/M procedure codes to start July 1,* **Page 25**
- *Provider portal pointers: Claims status inquiry process,* **Page 28**



Pharmacy news roundup

To view all — including the most recent — pharmacy-related provider alerts

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 *Read Alerts* button in the Alerts box.
6. Click *Pharmacy* on the left to limit your view to show only pharmacy alerts.

Here's a summary of pharmacy-related provider alerts from March and April 2025.

Tip: You can **subscribe** to *Provider Alerts Weekly* to receive a weekly email with links to the previous week's provider alerts.

April 2025

- **Starting Aug. 1, 2025, we'll change how we cover Revlimid (PDF)**
- **Provider websites unavailable overnight April 25-26 (PDF)**
- **Update: Selarsdi to require prior authorization for most members (PDF)**
- **Qfitlia SC and some denosumab products to require prior authorization for most commercial members for dates of service on or after April 11 (PDF)**
- **Bill HCPCS code J3490 for Depo-Provera for commercial members (PDF)**

March 2025

- **Medicare Advantage prior authorization requests submitted through NovoLogix must be submitted through a different application starting July 1 (PDF)**
- **Update: Commercial prior authorization requests submitted through NovoLogix must be submitted through a different application starting April 21 (PDF)**
- **Complete the Continuity of Care Guideline in the e referral system for some Medicare Advantage members starting April 3 (PDF)**
- **Step therapy required for Keytruda and Opdivo for nasopharyngeal cancer for most members starting June 18 (PDF)**
- **Update: Omlyclo and omalizumab-igec require prior authorization for most commercial members for dates of service on or after March 27 (PDF)**
- **Encelto to require prior authorization for most members (PDF)**
- **Denosumab-dssb SC, Osenvelt SC and Stoboclo SC to require prior authorization (PDF)**
- **How we communicate changes to medical policies for medical benefit drugs that require prior authorization for commercial members (PDF)**

Pharmacy News

Bill HCPCS code J3490 for Depo-Provera for commercial members

When submitting claims for Depo-Provera® (medroxyprogesterone) for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members, do the following:

- Bill HCPCS code J3490
- Include clinical documentation
- Include the appropriate National Drug Code, or NDC

Use RC Claim Assist to identify the correct HCPCS code based on the NDC. For more information, see the document titled ***Using the RC Claim Assist tool: Frequently asked questions for providers***.

The Blue Cross or BCN Pharmacy department will look for the information specified above when reviewing claims for Depo-Provera.

Note: Although Depo-Provera has an active HCPCS code, refer to RC Claim Assist to determine how to bill.

HelpScript enrollment service for manufacturer copay assistance will start July 1 for select medical benefit drugs for some BCN commercial members

Blue Care Network is working with HelpScript to coordinate member enrollment in manufacturer copay assistance programs for certain high-cost medical benefit drugs. Examples of the types of drugs for which assistance will be available are oncology drugs, ophthalmology drugs to treat diseases such as macular degeneration, and drugs used to treat autoimmune diseases such as psoriatic arthritis, rheumatoid arthritis and multiple sclerosis.

HelpScript's goals are to:

- Make it easier for you, the health care provider, to receive full reimbursement for drugs that are part of the program
- Improve medication adherence and clinical outcomes
- Ensure access to certain drugs with little or no cost to the member

Continued on following page

This service will start July 1, 2025. It will be available for members who have coverage through BCN commercial fully insured groups.

Exceptions: This service won't be available to members who have (1) high-deductible plans; (2) flexible spending accounts, health reimbursement arrangements or health savings accounts; (3) coverage through UAW Retiree Medical Benefits Trust non-Medicare plans; (4) coverage through the Blue Cross and Blue Shield Federal Employee Program®; or (5) a Medicare Advantage or Medicaid product as secondary coverage.

How will members learn about the HelpScript service?

Starting in mid- to late-June, HelpScript patient advocates will reach out to eligible members and provide one-on-one guidance to help them enroll for manufacturer assistance.

Specifically, HelpScript will reach out to eligible BCN commercial members who are already receiving a drug for which assistance will be available starting July 1 and to members who are newly prescribed a drug for which assistance is available.

How does this service affect provider offices?

- Enrollment

  When a patient enrolls for manufacturer copay assistance, a HelpScript patient advocate will contact your office to share enrollment details, including how you'll receive funds from the manufacturer.

  HelpScript will send a fax to your office to confirm the member's enrollment in manufacturer copay assistance.

  Note: HelpScript may reach out to your office for help contacting your patients about enrollment or to obtain clinical documentation required by the manufacturer.

- Billing

  Provider offices will need to do the following:

  1. Submit claims for the drugs to BCN for primary payment.
  2. Submit the BCN remittance advice to the manufacturer's copay assistance program for the amount shown as "member owed" to receive direct payment from the manufacturer.

     Note: See the document titled **Locating a voucher or remittance advice through our provider portal** for more information.

  If any remaining "member responsible" amount is owed to the provider office for a drug that's covered under the manufacturer copay assistance program after the steps above have been completed, HelpScript will automatically send payment directly to the provider office for that amount. HelpScript typically sends the payment within 14 to 21 business days after BCN finalizes its payment.

  When the billing process is complete, BCN commercial members who have active coverage and are enrolled in a manufacturer copay assistance program will have a $0 out-of-pocket cost.

Additional information

For questions, your office's billing department can call HelpScript at 1-833-807-4776 from 8 a.m. to 8 p.m. Monday through Friday.

By July 1, we'll update the document titled ***Drugs: For medication discounts, adherence and prior authorization determinations*** to include information about this program.

Notes:

- This service doesn't affect utilization management requirements for the medical benefit drugs that are part of the program. For example, drugs that have prior authorization, step therapy or site-of-care requirements will continue to have those requirements.
- If a member exhausts their manufacturer copay assistance funds, the drug will continue to be covered with no cost to the member, for as long as the member remains enrolled in the assistance program.

HelpScript is an independent company coordinating member enrollment in copay assistance programs for provider-administered drugs on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

Pharmacy News

We're changing how we cover Revlimid, starting August 1

Blue Cross Blue Shield of Michigan and Blue Care Network will change how we cover Revlimid® on the drug lists associated with our prescription drug plans, starting August 1, 2025. This change will affect most Blue Cross and BCN commercial members under the pharmacy benefit.

Brand name Revlimid will no longer be covered for members starting August 1, Instead, we'll cover the generic equivalent, lenalidomide. If they continue to stay on Revlimid, they'll be responsible for the full cost. Members can talk to their doctor if they have concerns about this change.

If the member's pharmacy is unable to fill their prescription with generic lenalidomide, Walgreens Specialty Pharmacy can fill their prescription. If they have questions, they can call Walgreens Specialty Pharmacy team at 1-866-515-1355.

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

- *How to protect yourself from NPI-related fraud,* **Page 1**
- *Quality Minute: Medication adherence and medication review,* **Page 13**
- *Provider portal pointers: Claims status inquiry process,* **Page 28**

Billing Bulletin

Fees for new telemedicine E/M procedure codes to start July 1

Blue Cross Blue Shield of Michigan and Blue Care Network will change practitioner fees for certain services provided on or after July 1, 2025. These changes may affect all health care providers — including behavioral health providers — for evaluation and management services provided through synchronous audio-video visits.

Commercial members

For Blue Cross and BCN commercial members, Blue Cross and BCN fee schedules are the primary source of information about fees. To find the fee schedules:

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. Scroll down, and then click on *Secure Provider Resources (Blue Cross and BCN).*
4. Click on the *Fee Schedule* drop-down menu and then click on one of the following:
   - *Blue Cross Professional Fee Schedules*
   - *BCN Fee Schedules*

Note: We published the article **Blue Cross' updates to practitioner fees will take effect July 1** on March 31, 2025, in the April 2025 issue of *The Record*.

Medicare Advantage members

For Medicare Plus Blue℠ and BCN Advantage℠ members, follow the guidance from the Centers for Medicare & Medicaid Services when billing for telemedicine E/M 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.

Submit separate claims for well newborn and sick newborn baby services for BCN members

As a reminder, facilities should submit separate Blue Care Network claims for services provided to well newborn babies and sick newborn babies.

- Well newborn services should be billed when newborn babies are discharged home with their mothers from the newborn nursery. These services are identified by revenue codes 0170, 0171 and 0172.
- Sick newborn services should be billed when the baby stays in the hospital longer than their mother. These services are identified by revenue codes 0173 and 0174.

We're updating our systems to prevent BCN claims that include services for both well and sick newborns from being accepted. Going forward, claims that include both will receive a front-end edit. Health care providers will need to correct and resubmit the services on separate claims.

To view facility claim examples for BCN well newborn and sick newborn services:

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* in the menu bar and then click *BCN and BCN Advantage*.
6. Scroll to the "Facility Claims – Billing Instructions" section.
7. In the "Inpatient services" subsection, click these links:
   - *Newborn nursery care, sick baby*
   - *Newborn nursery care, well baby*

2025 billing changes affect provider-delivered care management services

Here's a summary of 2025 billing changes that affect provider-delivered care management services for Medicare Plus Blue℠ and BCN Advantage℠ members.

Advanced primary care management services

For 2025, the following HCPCS codes have been added for advanced primary care management, or APCM, services: G0556, G0557 and G0558. These HCPCS codes:

- Are billable only for Medicare Advantage members who meet criteria
- Were approved in the Centers for Medicare & Medicaid Services final rule in November 2024

The HCPCS codes for APCM services are considered duplicative with procedure codes for chronic care management, principal care management, provider-delivered care management and transitional care management services. As a result, the APCM codes aren't payable in the same month as the CCM, PCM, PDCM or TCM codes.

Note: The new codes for APCM aren't included in Blue Cross Blue Shield of Michigan or Blue Care Network's PDCM program.

Important: HCPCS codes G0556, G0557 and G0558 aren't payable for Blue Cross or BCN commercial members.

Rural health clinics and federally qualified health clinics

As outlined by CMS, billing will change as follows for Medicare Advantage members who receive care management services at RHCs or FQHCs.

Dates of service	RHCs and FQHCs must…
On or before June 30, 2025	Continue to bill HCPCS code G0511.
On or after July 1, 2025	Do **one** of the following: • Bill the new APCM HCPCS codes (G0556, G0557 and G0558), **OR** • Bill the following procedure codes: - Chronic care management procedure codes *99487, *99489, *99490, *99491, *99437, *99439 - Principal care management procedure codes *99424, *99425, *99426, *99427 - Transitional care management procedure codes *99495, *99496 Procedure codes for CCM, PCM and TCM services are considered duplicative with the HCPCS codes for APCM services. As a result, the APCM codes aren't payable in the same month as the CCM, PCM or TCM codes.

Medicare Advantage members who receive the above services at RHCs or FQHCs **aren't** included in the denominator for our PDCM program.

Provider portal pointers

An ongoing series of tips and tricks designed to help you do your job more efficiently by getting the most out of the applications and tools available on our provider portal.

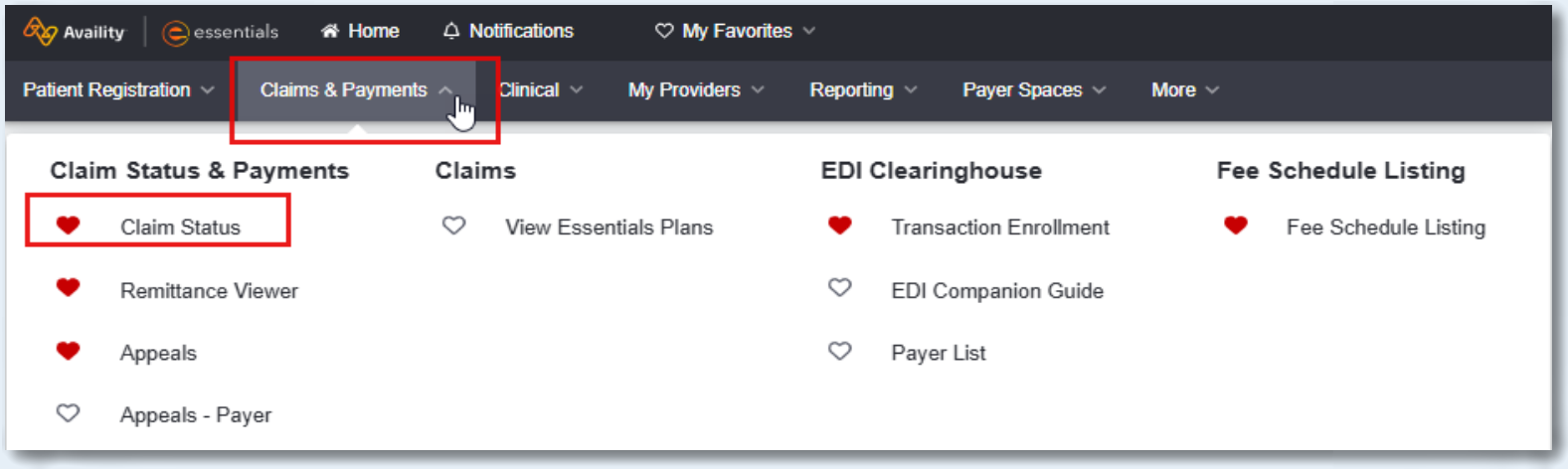
Claims status inquiry process

The claims status inquiry process is designed to streamline access to insurance claim statuses, identify issues and dispute claims, when necessary.

Note: To conduct a claims status inquiry, administrators must first assign the user the Claims Status role using Manage My Team(s), as previously discussed on **page 9 of the May-June issue of *BCN Provider News***. Without this role, users will be unable to access the claims status inquiry tool within the portal.

The steps to conduct a claims status inquiry are as follows:

1. Log in to the provider portal at **availity.com**.
2. For all lines of business, click on *Claims & Payments* on the menu bar and then click on *Claim Status*.



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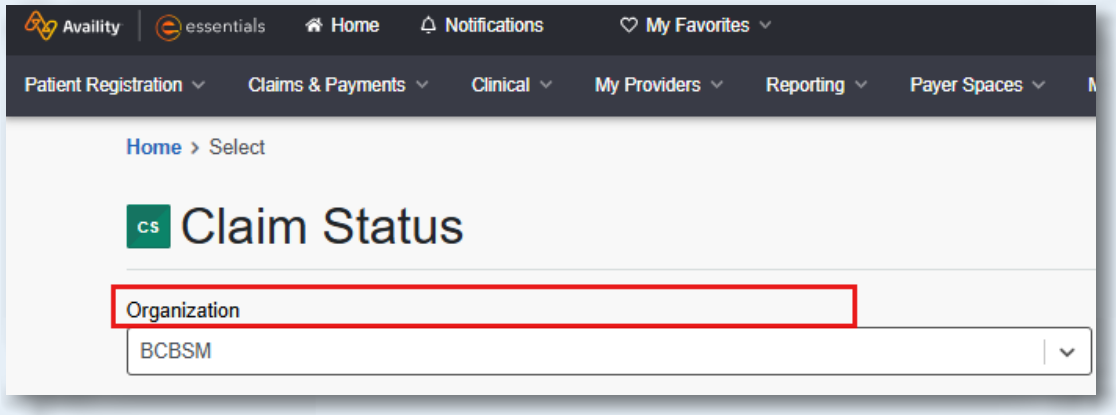
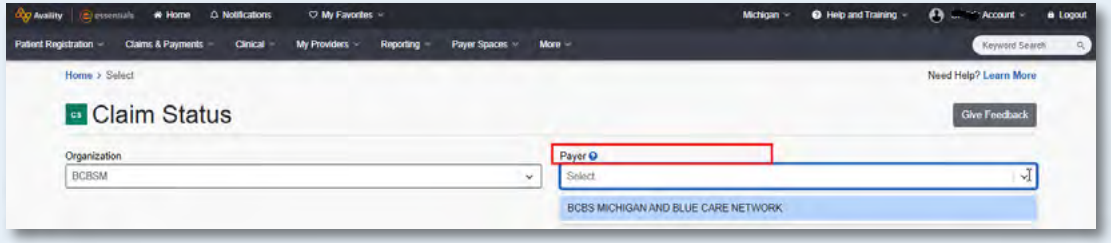
3. Select the appropriate Organization from the drop-down menu.

   If the user is tied to only one organization, it will be selected automatically. Those with access to multiple organizations will see all options displayed alphabetically.



4. Select the appropriate Payer from the drop-down menu. For Michigan users, this is typically *BCBS Michigan and Blue Care Network*, which includes lines of business such as Blue Cross commercial, BCN commercial, BCN Advantage, Medicare Plus Blue, FEP (Federal Employee Program) and other Blue plans.

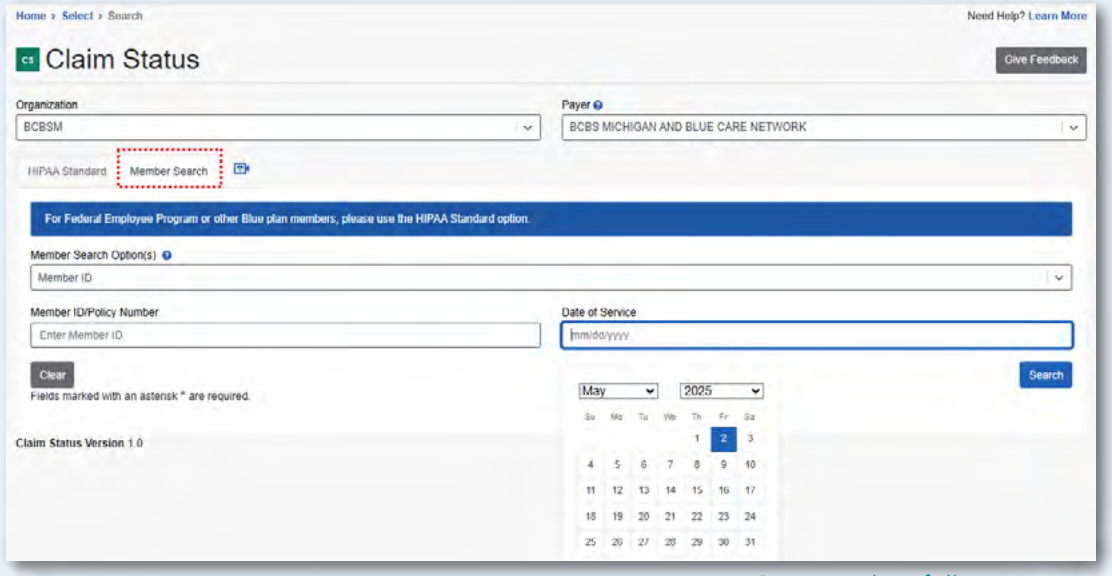


5. Users have two search options to choose from when looking into the status of a claim:

   - **Option 1:** Member Search

     Claim searches are typically conducted using the Member ID (e.g., enrollee or contract number) and the Date of Service (DOS) that should not exceed three and half years in the past.

     Hint: In cases where a patient appears multiple times due to coverage types or group changes, select the correct record carefully.



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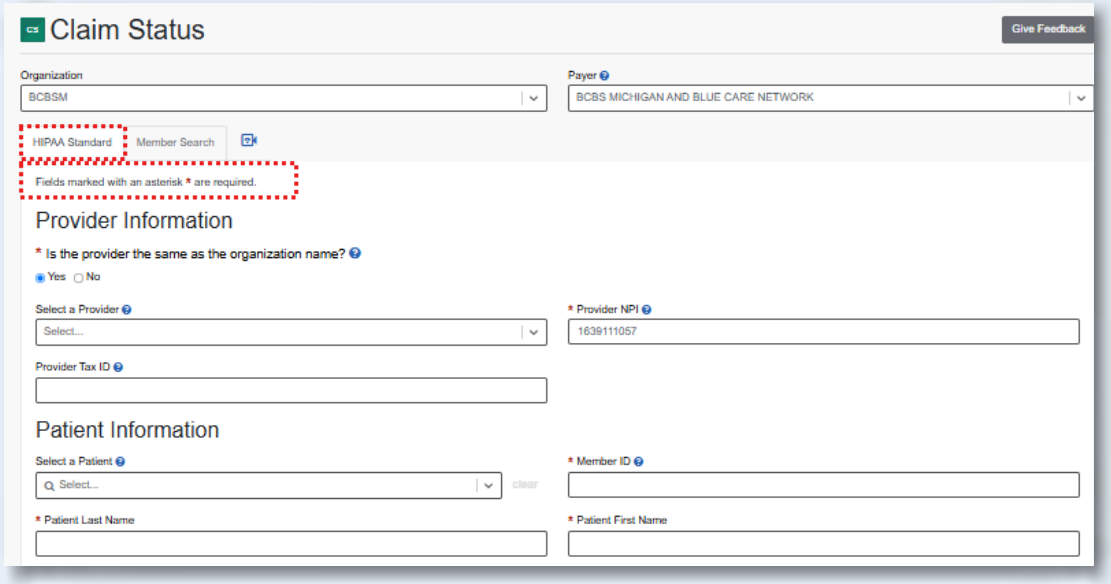
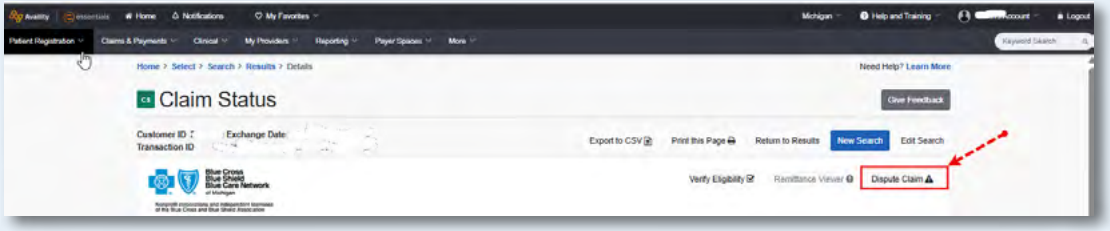
- **Option 2:** HIPAA Standard

  For patients classified under FEP (Federal Employee Program) or OOS (Out of State), users should bypass the member search option and use the HIPAA Standard tab.

  Hint: For best search results, only enter data for required fields marked with an asterisk.



6. Users can click the **Dispute Claim** button for Blue Cross commercial, BCN and Medicare Plus Blue claims (only) if they meet the following criteria:
   - There is a clinical edit.
   - Claims were submitted within the last 45 days.



Note: Appeals are based on EX Codes, which differ for each line of business.

To access EX code lists for each line of business:

1. Log in to the provider portal at **availity.com**.
2. Click on *Payer Spaces* on the menu bar and then click on the Blue Cross and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources (Blue Cross and BCN).*
5. Click *Codes and Criteria* in the *Billing and Claims* tab.
6. Scroll down to the Clinical Editing section to view all available EX code lists.

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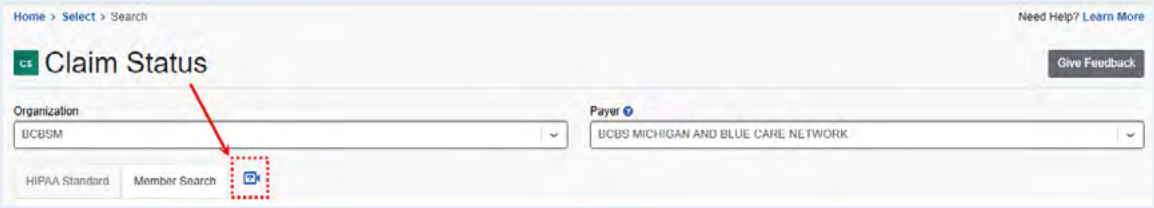
Additional help is available

A short video demonstrating the claims status process is also available. To view the video, click the camera icon on the Claim Status page.



Help us help you!

If you have a suggestion for a provider portal topic you would like to see in future issues of *BCN Provider News*, contact us at **bcnprovidernews@bcbsm.com**.

Reminder: Follow correct billing guidelines when submitting claims for secondary payment

Health care facilities should submit secondary claims with a B3 amount equal to total charges **only** when the primary payer hasn't made payment. We're receiving claims that are billed incorrectly when payment has already been made by the primary payer. This is causing us to manually review and correct the claims.

See the following examples that demonstrate correct billing.

Example 1 – Coordination of Benefits COB – Coordination of Benefits COB

Value codes and amounts (FL 39-41 A-D) Electronic 837I loop 2300 HI01-2 through HI12- 2

- Report code "B3" (total charge) if the primary payer rejected the claim.
- Report code "B3" (total charge) and "C3" (total charge) if the primary payer pays and the secondary payer rejects or terminates benefits.

Example 2 – Coordination of Benefits COB – Primary Payer Rejected Entire Claim

Value codes and amounts (FL 39-41 A-D) Electronic 837I loop 2300 HI01-2 through HI12- 2

- Report "A3" total amount billed to primary payer.
- Report code "B3" (estimated responsibility payer B) to indicate the amount estimated by the provider to be paid by the secondary payer.

Example 3 - Coordination of Benefits COB – Primary Applied Deductible

Value codes and amounts (FL 39-41 A-D) Electronic 837I loop 2300 HI01-2 through HI12- 2

- Report code "A1" (deductible payer A). Bill the CAS code equivalent.
  - When billing electronically, report in loop 2320 or 2430 CAS segment, PR*1* deductible amount.
- Report code "B3" (estimated responsibility payer B) to indicate the estimated amount due from the secondary payer.

For more information on billing, refer to our **provider manuals**.

Billing Bulletin

BCN Provider *News*
Feedback

Coding corner: Acute conditions not typically managed in office setting

Accurate diagnosis coding is essential in risk-adjusted payment models, including Medicare Advantage and the ACA Marketplace. Some conditions, especially acute or life-threatening diagnoses, are expected to be treated in inpatient or emergency settings, not routinely managed in physician offices (place of service 11). Misreporting these diagnoses in outpatient settings can lead to improper risk score inflation and noncompliance with ICD-10 coding guidelines.

The following are examples of acute conditions that shouldn't be coded during an office visit unless clearly supported by documentation and appropriate clinical context.

- **Cerebrovascular accident and acute ill-defined stroke**

  An acute cerebrovascular accident, or CVA, is a medical emergency requiring inpatient care. If the patient has a history of stroke, the outpatient documentation must reflect "history of CVA" and specify any lasting deficits (for example, hemiparesis or aphasia) using appropriate late effects codes. Avoid using acute CVA codes (for example, I63.x) in outpatient settings unless the event is actively occurring and the patient is being evaluated emergently.

Continued on following page

- **Unstable angina, acute coronary syndrome and NSTEMI**

  Unstable angina, acute coronary syndrome, or ACS, and non-ST-elevation myocardial infarction, or NSTEMI, represent acute cardiac syndromes and are typically managed in emergency departments or inpatient settings. Coding these diagnoses in an outpatient setting requires clear documentation that the patient was transferred for emergent evaluation. Office visits should not assign ACS, NSTEMI or unstable angina codes unless supported by documentation of active symptoms prompting urgent evaluation.

- **Acute respiratory failure and acute on chronic respiratory failure**

  Acute respiratory failure and acute on chronic respiratory failure signify a critical loss of respiratory function requiring immediate intervention and usually hospitalization. Coding acute respiratory failure in the office requires documentation of a recent hospitalization or a direct referral to higher care. If the patient has chronic respiratory failure without acute decompensation, use the chronic condition code (for example, J96.10).

- **Sepsis and septicemia**

  Sepsis represents a systemic, life-threatening response to infection and is almost always managed in a hospital. A diagnosis of sepsis in an office setting should only be coded if the provider is directly involved in acute care coordination, monitoring medications for treatment or the patient is being transferred for emergent treatment. If sepsis occurred in the past, and there are ongoing sequelae, use history of sepsis or appropriate late effect codes.

- **Acute myocardial infarction**

  Acute myocardial infarction, or MI, should only be coded when the patient is experiencing the event and receiving emergent treatment, typically in a hospital setting (POS 21 or 23). Outpatient visits after the acute episode must indicate a history of MI if the event occurred more than four weeks prior. Avoid using acute MI codes (for example, I21.x) in an office visit without supporting documentation of a recent or active event under evaluation. If follow-up of an NSTEMI is done within four weeks of a hospital stay, and the provider appropriately documents the care and treatment of the NSTEMI in the record, the NSTEMI can be coded on the outpatient record.

Key takeaways for providers and coders

- Acute diagnoses must reflect the clinical setting and timing: emergent or inpatient care vs. follow-up in outpatient settings.
- When the condition is no longer active, use history of or sequelae/late effects codes.
- Ensure documentation supports medical necessity, timing and location of care.
- Use caution when coding conditions commonly associated with hospital-level care during routine office visits.
- Follow current ICD-10-CM and HHS-HCC/CMS-HCC model guidelines for valid risk adjustment data capture.

Billing Bulletin

Clinical editing updates

In support of correct coding and payment accuracy, we are providing the information below to keep you informed about forthcoming payment policy updates, new policies and coding reminders.

This issue's updates:

- Blue Cross Blue Shield of Michigan commercial
  - Prostate specimen re-bundle
  - Prostate biopsy specimen analysis
  - Reminder: Postpartum and global delivery
  - Reminder: Modifier 79
  - Reminder: Preadmission tests
  - Reminder: Bill claims with correct place of service
- Medicare Plus Blue℠
  - Radiology procedures requiring anatomical modifiers
- Blue Care Network commercial
  - Telehealth
- BCN Advantage℠
  - Office, outpatient E/M visit complexity add-on code G2211

Clinical Editing Billing Tips

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

Referral Roundup

Reminder: Prior authorization no longer required for pain management procedures for Medicare Advantage members

For dates of service on or after May 1, 2025, Blue Cross Blue Shield of Michigan and Blue Care Network no longer require prior authorization for pain management procedures for Medicare Plus Blue℠ and BCN Advantage℠ members.

We previously announced this change in a **Jan. 31, 2025, provider alert**.

For pain management procedures with dates of service on or before April 30, 2025, health care providers can submit retroactive authorization requests to TurningPoint Healthcare Solutions through July 31, 2025.

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

Medicare Advantage members can request a non-emergency transfer from one acute care facility to another at any time

For Blue Cross Blue Shield of Michigan and Blue Care Network members, facilities must obtain authorization from Blue Cross or BCN prior to any non-emergency transfer of a member from one acute care inpatient medical / surgical (non-behavioral health) facility to another.

As a reminder, Medicare Advantage (Medicare Plus Blue℠ and BCN Advantage℠) members who are currently admitted to an acute care inpatient medical / surgical facility can request a non-emergency transfer to another acute care inpatient facility of their choice at any time.

For more information about acute care facility transfers, including urgent transfers, refer to the document **Submitting acute inpatient authorization requests: Frequently asked questions for providers**.

Referral Roundup

Best practices for submitting prior authorization requests with InterQual Connect questions through the e-referral system

After answering InterQual Connect questions in the e-referral system, do the following to help ensure prior authorization requests are processed as quickly as possible:

- **Always click *Review Summary***

  Refer to Step 1 below for additional details.

- **Always click *Complete* to submit requests**

  The *Save Review* button has been renamed to *Save For Later*. Don't click the *Save For Later* button, as it will cause your request to pend even if criteria are met and will delay the processing of your request. Refer to Step 2 below.

Here's what to do to submit a request after answering InterQual Connect questions in the e-referral system:

1. On the Recommendations screen, do one of the following:

If…	Do this…
The recommended service is automatically selected. **Tip**: Look for a check mark to ensure the service is selected. See the image below for an example.	Click *Review Summary*. **Important**: If you don't select a recommended service, cases that meet criteria will pend for review. This will delay our processing of your request.
The recommended service is not automatically selected.	Select the service, and then click *Review Summary*.
There is no recommendation.	Click *Review Summary*.

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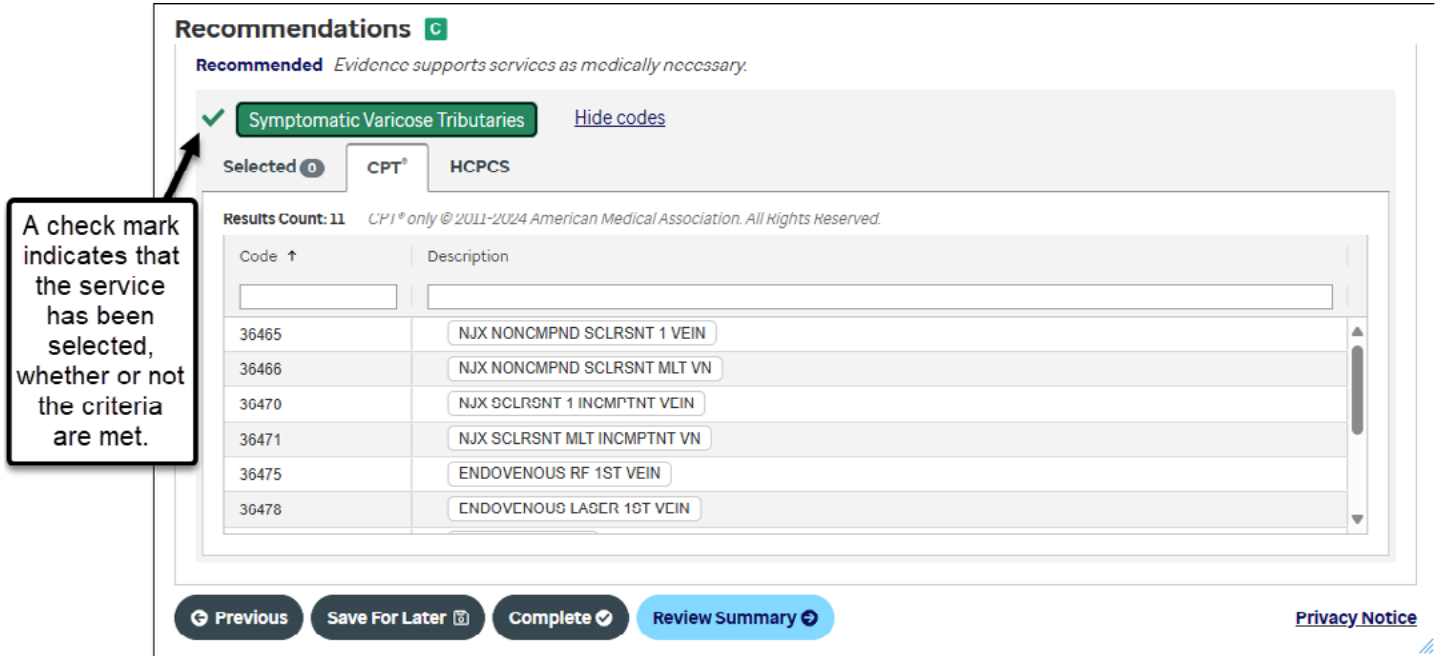
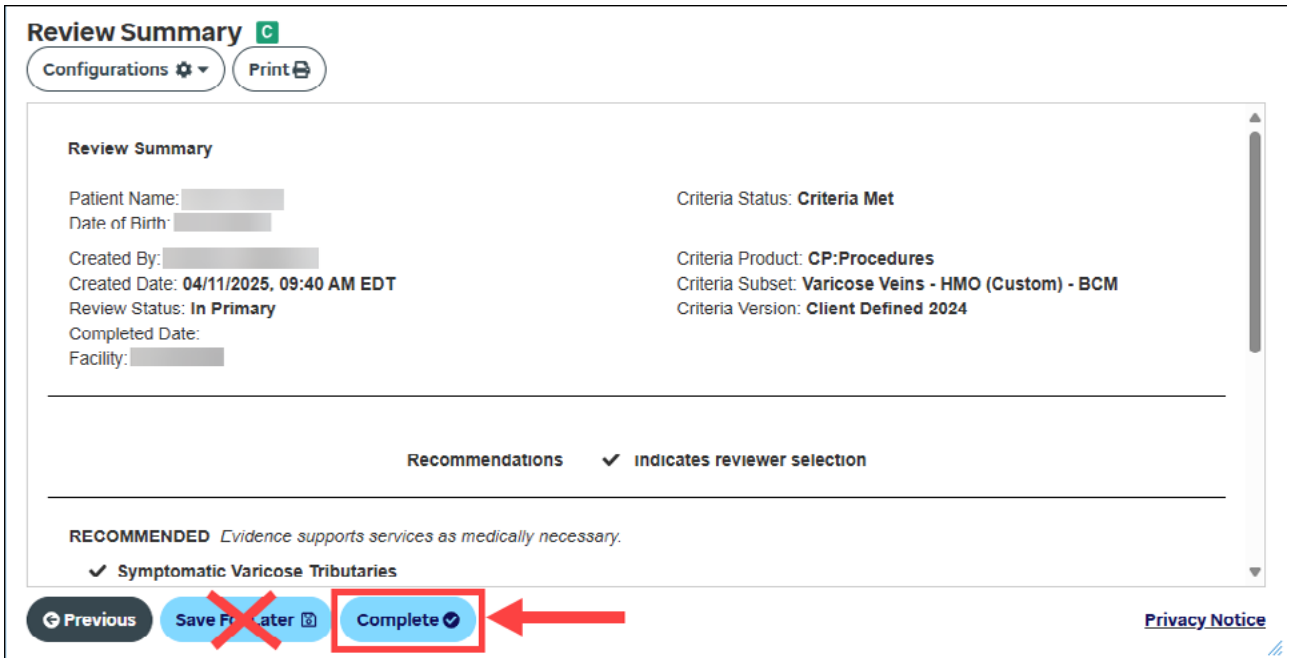
Referral Roundup



2. On the Review Summary screen, review the summary and click *Complete* to submit the request.

   Important: Don't click *Save For Later*. This will cause your request to pend even if criteria are met and will delay the processing of your request. Always click *Complete* to submit the request.



Referral Roundup

BCN Provider *News*

Feedback

Changes coming to prior authorization process for in-lab sleep studies for most commercial members

Starting Oct. 1, 2025, Carelon Medical Benefits Management will no longer manage prior authorizations for in-lab sleep studies for most Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

These sleep studies will continue to require prior authorization, but the prior authorizations will be managed by Blue Cross and BCN. Submit prior authorization requests through the e-referral system.

Watch for provider alerts and articles in *BCN Provider News* with additional information about this change, including:

- Training opportunities, which will cover the streamlined submission process
- Updates to our provider communications and documents for this program

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 prior authorization for select services managed by Blue Cross and BCN started March 23

On March 23, Blue Cross Blue Shield of Michigan and Blue Care Network changed prior authorization requirements for some services.

We've also updated the document **Preview questionnaires and medical necessity criteria** (previously titled *Authorization criteria and preview questionnaires*) on the **ereferrals.bcbsm.com** website to reflect the questionnaire changes.

Prior authorization requirement and questionnaires changes

We changed prior authorization and questionnaire changes to select services as follows.

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Referral Roundup

Service	Affected lines of business	What's changing
Abdominoplasty	• BCN commercial • BCN Advantage	Procedure code *15847 no longer requires prior authorization. The *Abdominoplasty* questionnaire will continue to open for procedure code *15830.
Blepharoplasty	• Medicare Plus Blue • BCN commercial • BCN Advantage	Select cases will auto-approve when prior authorization requests include an appropriate diagnosis code. The *Blepharoplasty and repair of brow ptosis* questionnaire will open only when prior authorization requests don't include an appropriate diagnosis code. This change affects procedure codes *15822, *15823, *67900, *67901, *67902, *67903, *67904, *67906 and *67908.
Gastric pacing/stimulation	• Medicare Plus Blue • BCN commercial • BCN Advantage	Procedure codes *43882 and *64595 will no longer require prior authorization. The *Gastric stimulation* questionnaire in the e-referral system: • Will no longer open for procedure code *64590. However, this code will continue to require prior authorization. • Will continue to open for procedure codes *43647, *43648, *43881, *95980, *95981, *95982.
Temporomandibular joint surgery	• BCN commercial • BCN Advantage	The *Temporomandibular joint surgery* questionnaire will no longer open for BCN Advantage members. However, procedure codes *20605, *20606, *21010, *21050, *21060, *21070, *21240, *21242, *21243, *21490 and *29804 will continue to require prior authorization. **Note**: Most Medicare Advantage plans no longer cover temporomandibular joint disorders or dysfunction services and treatments. Affected procedure codes include: *20605, *20606, *21010, *21050, *21060, *21070, *21240, *21242, *21243, *21490 and *29804.
Various	• BCN commercial • BCN Advantage	**For BCN commercial**: • Procedure codes *92517 and *92519 no longer require prior authorization. • We won't accept prior authorization for the following procedure codes because the subscriber contracts will no longer cover the services: G0019, G0022, G0023, G0024, G0316, G0317 and G0318. **For BCN commercial and BCN Advantage:** Procedure code G0463 no longer requires prior authorization.

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Preview questionnaires and medical necessity criteria

For some of the above services, health care providers are prompted to complete questionnaires in the e-referral system. Refer to the **Preview questionnaires and medical necessity criteria** for:

- Links to preview questionnaires that show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time
- Information about how to access medical necessity criteria and the criteria source for each service

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

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

- *How to protect yourself from NPI-related fraud,* **Page 1**
- *Complete Continuity of Care Guideline in e-referral system for some Medicare Advantage members,* **Page 9**
- *Pharmacy news roundup,* **Page 21**
- *Provider portal pointers: Claims status inquiry process,* **Page 28**

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