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# What you need to know about doing business with Blue Cross

Here's a summary of key information our participating providers need to know about doing business with Blue Cross Blue Shield of Michigan.

#### How to access our online provider manuals

Everything you need to do business with Blue Cross is included in our online provider manuals. To access the provider manual through our provider portal:

1. Log in to availity.com.

Confidence comes with every card.

- 2. Click on Payer Spaces on the Availity menu bar.
- 3. Click on the Blue Cross and BCN logo.
- 4. Click on Provider manuals under the Resources tab.

#### Access and availability guidelines

When a member requests an appointment, Blue Cross providers are required to comply with the following standards.

### Access to primary care

- Emergency: Immediately
- Urgent care: Immediately
- Not urgent, requires medical attention: Seven days
- Regular and routine care (including follow-up and preventive care): Within 30 days
- After-hours care: 24 hours, seven days a week

# Access to behavioral health care

- Life-threatening emergency: Immediately
- Non-life-threatening emergency: Immediately
- Urgent care: Immediately
- Not urgent, requires medical attention: Seven days
- Initial routine visit (not including follow-ups): Within 10 days
- Regular and routine care (including follow-up and preventive care): Within 30 days

### Access to specialty care

 Regular and routine care (including follow-up and preventive care): Within 30 days

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For more detailed information, see the *PPO Policies* chapter in the provider manual or contact your provider consultant.

#### Affirmative statement about incentives

Utilization management decisions are based only on appropriateness of care and service and existence of coverage. See the affirmation statement in the Participation chapter of the provider manual. It's located in the section titled Requirements and Guidelines.

#### Comprehensive care management

To learn about Blue Cross comprehensive care management, use your online provider manual Health, Well-being, and Coordinated Care chapter. To find the information on **bcbsm.com**, click on the *Providers* tab. Type "Blue Cross Coordinated Care" in the search engine. Scroll down to For Providers: Blue Cross Coordinated Care.

### Criteria used for level of care utilization management decisions

For hospitals and facilities, Blue Cross uses InterQual criteria to assess medical necessity and the appropriate level of care. Criteria encompasses acute care (adult and pediatric), rehabilitation (adult and pediatric), long-term acute care, skilled nursing facility and home health care.

Blue Cross modifications of the InterQual criteria (local rules) can be accessed online by following these steps:

- 1. Log in at **availity.com**.
- 2. Click Payer Spaces at the top.
- 3. Click the BCBSM BCN logo to reach our payer space.
- 4. Click Secure Provider Resources (Blue Cross and BCN) in the Resources tab.
- 5. Click Codes and Criteria in the Billing and Claims tab.

If you have questions about InterQual, send an email to InterQualSupport@Optum.com. Provide your name and address and reference that the question pertains to InterQual.

Behavioral health criteria can be found in the in the Behavioral Health Services section on the Services That Need Prior Authorization page on bcsbm.com.

#### Medical policies

To review additional Blue Cross medical policies, go to **bcbsm.com/providers**:

- 1. Click Resources.
- 2. Scroll down to the section that says Looking for medical policies?
- 3. Click Search for Medical Policies.

#### Member rights and responsibilities

Blue Cross outlines the rights and responsibilities of our members, including how members can file a complaint or grievance. Go to <a href="bcbsm.com">bcbsm.com</a>, type "Member Rights and Responsibilities" in the search field. Scroll down to <a href="Rights">Rights</a> and <a href="Responsibilities">Responsibilities</a> for PPO Members, or <a href="Rights">Rights</a> and <a href="Responsibilities">Responsibilities</a> for HMO Members

#### Pharmacy management

It's important for you to be familiar with our drug lists and our pharmacy management programs, such as step therapy, quantity limits, dose optimization, use of generics and specialty pharmacy. You also need to know how to request prior authorization for drugs covered under the pharmacy and medical benefit or exception requests and the information needed to support your request.

**Note**: Generic substitution may be required for Blue Cross members. If both the generic and brand name are listed on our drug list, members are encouraged to receive the generic equivalent when available. Some members may be required to pay the difference between the brandname and generic drug, as well as applicable copay, depending on the member's plan.

For more details, go to **bcbsm.com**, click on *Providers*, and then click on *Resources*. Scroll down and click *Access pharmacy resources* to access the **Pharmacy Resources** for **Providers** webpage.

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We recommend you visit this page at least quarterly to access our pharmacy procedures, drug lists including the *Prior Authorization Medical Drug List* and the *FEP Medical Drug List*, and to view updates. Another useful link for providers is **bcbsm.com/rxinfo**. The page contains links to the drug lists, prior authorization and step therapy requirements, quantity limit lists and alternatives for nonpreferred-brand and nonformulary drugs. You can also call 1-800-437-3803 for the most up-to-date pharmaceutical information.

#### Translation services

Members who need language assistance can call Customer Service at the number on the back of their Blue Cross member ID card. TDD/TTY users, call 711.

#### Utilization management staff availability

Department telephone numbers and hours are shown in the "Appeals and problem resolution" chapter of the provider manuals.

### Behavioral health care – Blue Cross Behavioral Health<sup>SM</sup>

#### Contact information:

- Commercial PPO and Traditional programs: 1-800-762-2382
- Federal Employee Program: 1-800-342-5891
- United Auto Workers Retiree Medical Benefits Trust (URMBT employer group): 1-877-228-3912

#### For more information

- Information about our programs and additional resources are available at **bcbsm.com/important-information/**.
- To request a printed copy of any of the information contained in this article, call Health Care Value Quality Management at 248-455-2808.
- If you have any questions about the information in this article, contact your provider consultant.



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# Use our new online tool to enhance your provider directory listing

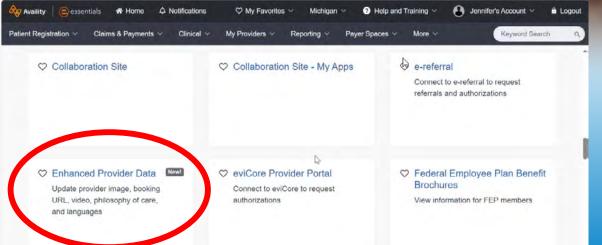
Blue Cross Blue Shield of Michigan offers Enhanced Provider Data, a new online tool available on our provider portal designed to help you strengthen your Blue Cross and Blue Care Network provider directory listing. If you are an independent provider not affiliated with a large health system, you can use Enhanced Provider Data to include additional, personalized information to help patients seeking care better understand you and your practice, including:

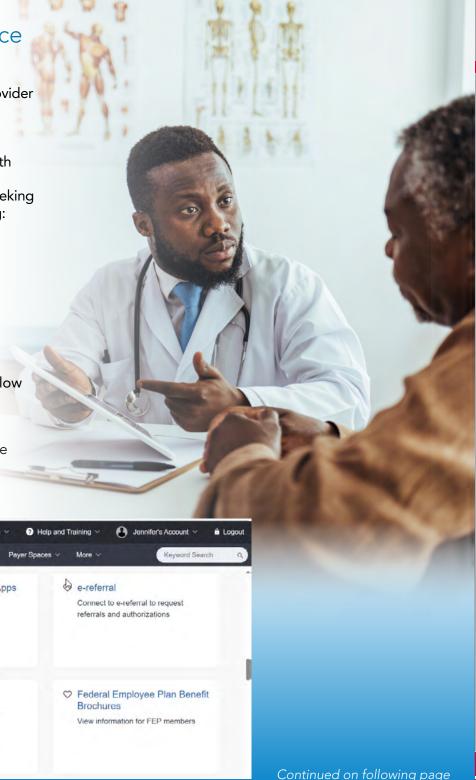
- A recent photo
- Languages spoken
- Your philosophy of care
- A link to an online video
- An online booking URL

#### How to access

To access the Enhanced Provider Data online tool, follow these steps:

- 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. Under the Applications tab, click on the Enhanced Provider Data tile.





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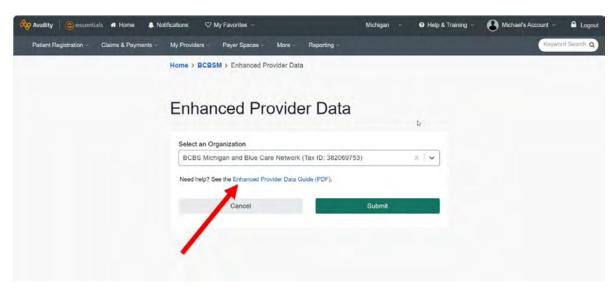
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4. Click Submit to continue.

For complete information on how to use the tool, as well as a list of Frequently Asked Questions, click **Enhanced Provider Data Guide (PDF)**.



#### Only independent providers can access Enhanced Provider Data

If you're affiliated with a large health system, your provider directory data may already include these enhanced data points, and you will not be able to modify or add information using the Enhanced Provider Data tool. Health systems providing enhanced data on behalf of their physicians participating include:

- Beacon Health System
- Bellin Health
- Corewell Health
- Munson Healthcare

If your health system is not listed and you're not sure whether or not it participates, you can send an inquiry to providersearch@bcbsm.com.

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# Blue Cross committed to coordination of care and exchange of information among practitioners

Blue Cross Blue Shield of Michigan collects and analyzes data each year to facilitate the coordination of care and exchange of information among specialists, behavioral health providers and primary care physicians following inpatient and outpatient visits.

Good two-way information exchange is especially important as we work to improve continuity and coordination of care within our network. For example, we not only need primary care providers to share information with specialists (including behavioral health specialists), but we need specialists to share patient information with the primary care providers as well.

Patient care that isn't coordinated across care settings results in confusion for members, increased risks to patient safety and unnecessary costs due to duplicate testing or procedures. Collaboration among health care providers can also greatly improve member satisfaction.

We can work together to accomplish our goal of 100% coordination of care among all providers by:

- Ensuring that specialists and behavioral health care providers have the correct contact information about the patient's primary care provider at the time of the visit
- Requesting that specialists and behavioral health providers forward post-visit information to the patient's primary care provider
- Ensuring that primary care providers forward a patient's medical information to any specialists or behavioral health providers who are treating the patient, as needed
- Asking behavioral health patients to sign an authorization for release of information or including a note of refusal in their chart if a patient declines to share information

We encourage all providers to continue to take steps to enhance the coordination of care and information exchange across the continuum of care to improve member satisfaction and care quality.

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#### What you need to know

To remain listed in our provider directories, including Find a Doctor, professional practitioners, facilities and organizational (or allied) providers must attest to their information as required.

### Reminder: Attest to provider data as required

Professional practitioners, facilities and organizational (or allied) health care providers must attest to their information as required to:

- Ensure affiliation with Blue Cross Blue Shield of Michigan or Blue Care Network isn't interrupted.
- Keep contact information up to date.
- Make sure claims payments aren't interrupted.

#### Facilities and organizational (allied) providers

Every 90 days, facilities and organizational (allied) providers with Type 2 national provider identifiers must update and attest to the following basic provider information in the Provider Data Management tool in our provider portal: 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.

To learn more, see the document Update and attest to facility and organizational provider information in the Provider Data Management tool within Availity Essentials.

#### **Professional practitioners**

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. Here's what professional practitioners need to do:

Frequency	What to do
Every 90 days	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.
Every 120 days	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.
	Credentialing status will end if practitioners fail to attest, and they'll need to reapply.

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

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.

For more information on attestation, go to our **Provider Data Attestations** page.

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#### What you need to know

Starting Jan. 1, 2026, there will be changes to the way primary care providers and group administrators submit quality data to Blue Cross Blue Shield of Michigan and Blue Care Network.

Primary source verification will be needed for three HEDIS® measures if entered into Health eBlue in 2026, and for all measures in 2027. Also starting in 2026, all measures manually entered into HeB must be entered by year end of the measurement year.

We'll provide more information in future editions of BCN Provider News.

# Health e-Blue update: New requirement to submit quality data for HEDIS measures

As part of our ongoing efforts to align with updated federal and accreditation standards, Blue Cross Blue Shield of Michigan and Blue Care Network are announcing important changes about quality data submissions.

effective Jan. 1, 2026, quality data submitted via Health e-Blue<sup>SM</sup> for incentive or contract performance must include primary source verification in the form of a medical record for these HEDIS® measures:

- Breast cancer screening
- Colorectal cancer screening
- Diabetes care eye exam

In addition, beginning in 2026, Health e-Blue entries for **all** measures must be completed by Dec. 31 of the measurement year. We'll no longer accept entries into the following year.

Starting on Jan. 1, 2027, Blue Cross and BCN will no longer accept Health e-Blue entries for **any** measure without primary source verification in the form of a medical record.

Later this year, we'll share more details about this important change, including how to submit the medical record.

This change is in direct response to the Centers for Medicare & Medicaid Services and the National Committee for Quality Assurance making significant updates to their quality measurement frameworks. CMS and NCQA are placing increased emphasis on the use of standardized data to ensure consistency, accuracy and comparability across health care organizations.

Failure to comply will result in the removal of a closed gap in Health e-Blue, incentives and contracts.

#### **Action steps**

To ensure a smooth transition and compliance with these changes:

- Prioritize sending measures electronically or through claims.
- Prepare to submit medical records for primary source verification in 2026. Make sure documentation for services related to quality measures is complete and accurate in each patient's medical record.
- Prepare for electronic medical record Physician Payer Quality Collaborative and Quality Measure Improvement audits for quality measures.
- Retire manual entry workflows, as applicable.

We recognize these changes may present challenges, and we're committed to supporting you through this transition. We'll provide additional information about this important change in future editions of *BCN Provider News*.

In the meantime, if you have questions or concerns about these new requirements, contact your physician organization or medical care group administrator. They can reach out as needed to their Blue Cross quality improvement performance consultant.

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



# Provider portal pointers

A new 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.

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#### Submitting an eligibility and benefits request

The ability to access our provider portal (availity.com) to determine patient eligibility and benefits enables you to more quickly and efficiently get the information you need to service your patients. However, if you are new to our provider portal, or only need to access patient eligibility and benefits information infrequently, you may have questions.

The good news is that the Eligibility & Benefits page has two useful tools to help you complete your request: *Watch a demo*, and *Find Help*. But first, let's look at the My Account Dashboard.

The My Account Dashboard lets users:

- Determine what applications/features they have access to.
- Update profile, upload picture, and reset password.
- Confirm organization administrator(s).



#### How to gain access to Eligibility & Benefits

To access this functionality, your organization administer must grant you access to the Eligibility and Benefits role under *Manage My Team(s)*.

To quickly locate your administrator, simply hover over the application/feature and click / need access. This will display who controls your access.

#### OR

1. Click on My Account.



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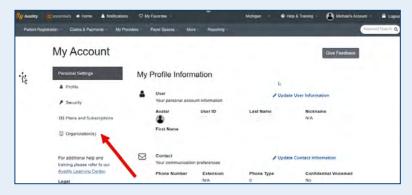
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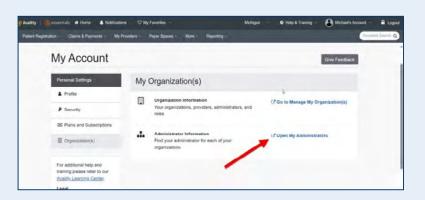


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2. Click on *Organization(s)* under the Personal Settings menu.



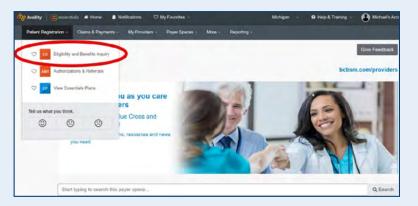
3. Click on Open My Administrators.



#### How to access the Eligibility & Benefits page

- 1. Log in to the provider portal at **availity.com**.
- 2. For all lines of business, click on *Patient Registration* on the menu bar and then click on *Eligibility and Benefits Inquiry.*

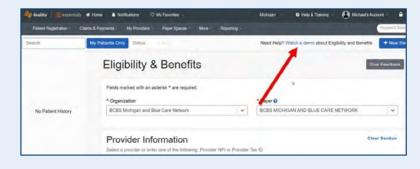
Lines of business include: Blue Cross (PPO) and Blue Care Network (HMO) commercial, BCN Advantage and Medicare Plus Blue (Medicare Advantage), Flexlink, out of state Blue Cross Blue Shield of Michigan plans and Federal Employee Program (FEP) contracts.



On the Eligibility & Benefits page you can choose to either watch a training video or access detailed step-by-step instructions on how to submit a request.

#### How to view the training video

1. Click the Watch a demo link.



2. Click the Start Course button.



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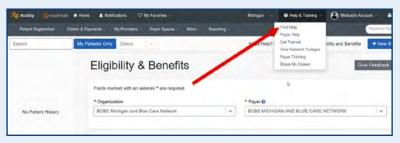
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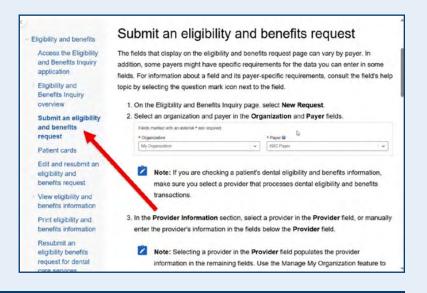
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#### How to view detailed step-by-step instructions

1. Click on Help & Training on the menu bar and then click on Find Help.



2. Click on Submit an eligibility and benefits request.



#### Eligibility and benefits request tips and tricks

- When searching for FEP or out of state (include prefix) coverage, search by Patient ID, Patient Last, First Name and DOB using the *Single Patient* tab, **not** the *Member Search* tab.
- In the As of Date field, enter the date for which you are verifying the patient's eligibility and benefits information. In many cases, you can enter a date up to 24 months in the past and up to the end of the current month for the future.
- For members with multiple groups, be sure to select the group and service type to view the benefits. Eligibility inquires for prior coverage is based on the contract number.
- In the Benefit/Service Type field, select the type of benefit or service for which you want to determine a patient's eligibility. **Tip**: Plan coverage code 30 is the most commonly used because it returns more than 10 different benefit types.

Be sure to look more provider portal pointers in future issues of this newsletter designed to help you do your job more efficiently by getting the most out of the applications and tools available on our provider portal.

#### 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.

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# Webinars for physicians, coders focus on documentation and coding

#### **Action item**

Register for our 2025 monthly Lunch & Learn webinars focusing on coding and documentation

In 2025, we'll continue to offer 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 topics for the sessions. All sessions start at noon Eastern time and should last for 30 minutes. Register for the sessions on the provider training website.

Session Date	Topic
Wed., May 14	Medical record documentation and MEAT
Wed., June 18	Pediatrics
Wed., July 18	Annual Medicare Wellness Visit
Wed., August 20	Coding modifiers and SDOH
Wed., Sept 17	Coding fractures and injuries
Wed. October 8	ICD-10 Updates for 2026
Wed. Nov. 19	Oncology
Wed. Dec. 17	CPT Updates for 2026

#### Provider training website access

If you have an Availity Essentials™ account you can access the provider training website this way:

- 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

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. 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:

Session date	Topic
March 5	Telehealth
April 15	HCC, status codes, and risk adjustment 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.



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### Register now for 2025 virtual provider symposium sessions

This year's virtual provider symposiums focusing on quality measures and review of Evaluation and Management 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.

#### HEDIS®/Star measure overview: The Golden Star **Awards**

For physicians and office staff responsible for closing gaps in care related to quality adult measures

Date	Time
May 15, 2025	10 - 11:00 a.m.
May 22, 2025	2 - 3:00 p.m.
June 5, 2025	2 - 3:00 p.m.
June 10, 2025	10 - 11:00 a.m.

#### Conducting an Internal Chart Audit: Livestreaming with April

For physicians, coders, billers and administrative staff

Date	Time
May 13, 2025	10 - 11:00 a.m.
May 21, 2025	2 - 3:00 p.m.
June 3, 2025	2 - 3:00 p.m.
June 17, 2025	10 - 11:00 a.m.

#### Register on the Provider training website

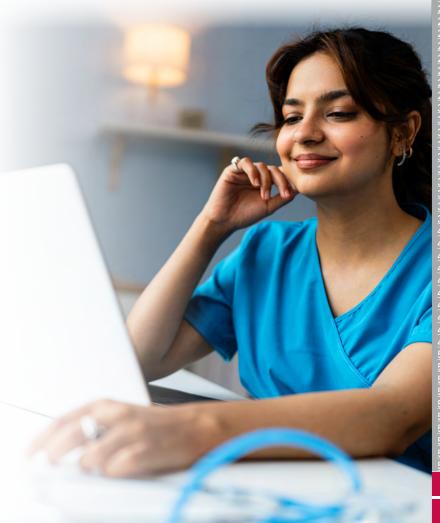
Provider portal users with an Availity Essentials account can access the provider training website on the Applications tab in the BCBSM/BCN Payer Space. Login through availity.com.

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.
- For more information on accessing the provider training website through the provider portal see this article: The Record December 2023.

HEDIS® is a registered trademark of the National Committee for Quality





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#### **Action item**

Visit our provider training site to find short courses related to the CMS Star and HEDIS measures and register for a webinar about best practices for prior authorizations with Carelon.

### Provider training courses available

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 new learning opportunities are available:

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

 Prior authorizations best practices – for requests managed by Carelon Medical Benefits Management

Register now for the webinar on June 17, from 1 to 2 p.m. Topics include important program updates for 2025 and case studies with Carelon provider portal walk-throughs. The goal is to help providers be successful when handling requests for prior authorization.

#### 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 <a href="mailto:ProviderTraining@bcbsm.com">ProviderTraining@bcbsm.com</a> 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

- Star, HEDIS Measure Tip sheets updated for 2025, Page 18
- Quality Minute Establishing patient care, Page 19
- Update: Commercial prior authorization requests submitted through NovoLogix must be submitted through a different application, starting April 21, Page 43

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### Talk to Medicare Advantage members about how to maintain independence, confidence

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

- Fall risks, including balance problems, and how to avoid them
- Physical activity, including how to get started and realistic exercise expectations
- Preventing urine leakage, for members who deal with incontinence
- Changes in mental health, including higher levels of stress, anxiety or depression
- 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 want our Medicare Advantage members to feel comfortable and confident sharing their concerns with you. We're suggesting they write them down and read from the list or hand it to you so you can start the conversation.

We also encourage you to discuss these issues with patients even if they don't initiate the conversation. Many patients don't ask questions about these topics because they forget, don't know what to ask, are embarrassed or 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 helps your patients 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 these sensitive issues.



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### Select Medicare Advantage members will receive Cologuard® test kit in July

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 Coloquard test kits in July. The kits will go to select Medicare Plus Blue<sup>SM</sup> PPO and BCN Advantage<sup>SM</sup> 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 Coloquard screening kit, excluding members who received a kit from Medicare Plus Blue PPO or BCN Advantage programs in 2023 or 2024, or are due for a Colonoscopy in 2025. Once completed, members will be encouraged to discuss test results with their primary care providers.

#### Test result notification:

	Results	Positive Results
Medicare Plus Blue PPO and BCN	Letter including member's results (negative only)	Certified letter for all members who received a positive result
Advantage member	Text message and email, if member provides contact information, notifying results are ready	Up to three phone call attempts to notify member of positive result
	Members can contact Exact Sciences Patient Support Line 24/7	If unable to contact member by phone, results will be mailed a second time (by standard mail)
Primary care	Mailed	
provider	Faxed, if fax number is provided	
	Provider offices can also receive results by conta the Epic Care portal or by requesting results at	

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.

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### Star, HEDIS Measure Tip sheets updated for 2025

We've updated our series of Star and HEDIS® Measure Tip sheets for 2025 and posted them on our provider portal, Availity Essentials™. These tip sheets have been developed to assist health care providers and their staff in their efforts to improve overall health care quality for their patients and prevent or control diseases and chronic conditions.

The new tip sheets are current as of this publication. However, when the National Committee for Quality Assurance, or NCQA, publishes final updates to the 2025 HEDIS specifications, we may need to update the tip sheets again. As updated versions are produced, we'll post the new ones and announce them in BCN Provider News.

The tip sheets highlight select measures in the Medicare Star Ratings program. Most of the measures featured in the tip sheets are HEDIS measures. HEDIS is one of the most widely used performance improvement tools in the U.S.

#### Accessing the tip sheets

The tip sheets are housed on the Secure Provider Resources section of Availity. You can get there by following these steps:

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

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



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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.

#### What you need to know

Members are required to select a primary care physician when joining health maintenance organization plans. In cases when our BCN commercial and BCN Advantage<sup>SM</sup> members don't select a PCP, they are auto assigned to one.

### Establishing patient care

It's important for our provider network to understand that if a patient hasn't established care with their assigned PCP, that patient won't be visible in Active Care Relationship Service or Admit, Discharge, and Transfer files. This can make managing their care more challenging and can impact the provider's quality measure performance.

#### What you can do

- Verify the patient's eligibility and PCP assignment at each visit.
- Tensure you have a process in place for regularly reviewing eligibility files and reaching out to patients who have yet to establish care.
- There is no copayment for a wellness visit performed by their selected PCP or one within the same practice. However, a specialist copay may apply if a patient sees a PCP who is not part of their selected PCP's practice. You can avoid this by asking them to select you as their PCP on the *Physician Selection Form*.
- <sup>™</sup> Use the Member Transfer Request Form if you've made three outreach attempts and you're not successful establishing the member's care. This form can be also be found on BCN Health e-Blue<sup>SM</sup> under Help Documents in the Resources section.

#### What we're doing as a health plan

We recognize that care coordination is not solely the provider's responsibility. Internally, we are working from the membership side to identify where members who haven't visited their PCP are receiving care. Through targeted outreach and various engagement programs, we aim to connect these members with their PCPs and support their healthcare needs.

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### How to obtain CGM products for commercial, Medicare Advantage members

As previously announced, the methods for obtaining continuous glucose monitor products have changed as follows.

Situation	Method for obtaining CGM products	
Commercial member has both medical and pharmacy	These Blue Cross Blue Shield of Michigan and Blue Care Network commercial members can obtain CGM products through <b>either</b> :	
<b>benefits</b> through Blue Cross or BCN	A durable medical equipment, or DME, provider under the medical benefit	
	A participating network pharmacy under the pharmacy benefit	
	Members' out-of-pocket costs for CGM products may vary depending on the benefit under which the CGM product is billed. Some members may have lower out-of-pocket costs under the pharmacy benefit compared to the medical benefit and vice versa.	
Commercial member has only medical benefits through	These Blue Cross and BCN commercial members must obtain CGM products through a DME provider under their medical benefit.	
Blue Cross or BCN	<b>Note</b> : These members may have pharmacy benefits through a different payer.	
Medicare Advantage members	Medicare Plus Blue and BCN Advantage members must obtain CGM products through a participating network pharmacy under their Part B benefits at the point of sale.	
	Blue Cross and BCN no longer cover CGM products dispensed by a contracted or noncontracted DME provider for Medicare Advantage members.	
	<b>Exception</b> : UAW Retiree Medical Benefits Trust members are excluded from this change. These members should continue to obtain their CGM products through a DME supplier.	

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To help health care providers navigate this change, we've published a new document titled **Continuous glucose** monitors: FAQs for prescribing providers. It includes:

- Steps to verify whether a commercial member has medical benefits, pharmacy benefits or both through Blue Cross or BCN
- What providers need to do so their patients can obtain CGM products
- Information about where to send orders for CGM products
- The criteria that must be met for CGM products to be payable
- Steps to find DME suppliers and pharmacies that dispense CGM products

- Information about prior authorization exemptions for physicians (M.D.s and D.O.s) who participate in the Michigan Collaborative for Type 2 Diabetes, or MCT2D, or in the Provider-Delivered Care Management, or PDCM, program
- Information for members

There are links to the new FAQ document on the Diabetes Supplies pages and the DME / P&O pages on **ereferrals**. **bcbsm.com**.

Here are links to earlier provider alerts about this change:

- For commercial members:
  - Some continuous glucose monitoring products available through participating network pharmacies for commercial members
- For Medicare Advantage members:

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

### Patient experience resources to support your practice

#### What you need to know

Blue Cross encourages health care providers to explore the expanded library of content on patient experience.

Blue Cross Blue Shield of Michigan has expanded the patient experience library of content, which is found on the provider training website. Patient experience refers to all interactions patients have with their doctors and staff. Positive patient experiences can drive patient loyalty and promote a cohesive environment for health care providers.

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.



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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.

#### Best practices to implement

We invite all providers to explore our three-part recorded webinar series, "Best Practices for Improving Patient Experience." These sessions are packed with insights to help your practice consistently deliver exceptional care and optimize patient care and interactions. Free materials are also available upon request and include posters and reminders for patients and staff.

In the "Best Practices for Improving Patient Experience" series, you'll gain practical tips and strategies used by doctors' offices in the following areas:

#### Appointment scheduling and wait-time management

- Discover how small adjustments can manage in-office wait times and reduce patient frustration.
- Learn best practices to ensure your patients receive urgent and routine appointments more promptly.

#### • Patient follow-up and medication reconciliation

- Explore recommendations to enhance the lab and test result follow-up process, minimizing frustration for both patients and staff.
- Understand how a streamlined medication reconciliation process can lead to more effective office visits.

#### Managing patient expectations for care referrals

- Find strategies for both communication and processes that manage patient expectations around specialist referrals.
- Learn best practices than can help your patients easily get the care, tests, and treatment they need.

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.

The expanded patient experience content is designed with you in mind, making it easier for practice leaders and staff to access a comprehensive collection of resources. You'll find best practices for streamlining office processes, enhancing patient interactions and boosting professional development – all in one convenient location.

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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### Professional reimbursement increased for select procedures performed in ambulatory surgical facilities

Blue Cross Blue Shield of Michigan and Blue Care Network professional reimbursement policy has increased professional allowed amounts by 15% over our professional fee schedule for select procedures when these procedures are performed in an ambulatory surgical facility. These changes went into effect by March 21, 2025, unless otherwise noted.

We're making these changes because technological and clinical advances allow more procedures to be safely performed in the ambulatory setting. However, we recognize that you may need to make some process changes when performing these procedures outside a hospital setting.

Increased professional payments that are payable now for certain procedures in the specialties as listed below for the lines of business noted.

Specialty	Blue Cross commercial	Medicare Plus Blue <sup>sM</sup>	BCN commercial	BCN Advantage <sup>sм</sup>
Ear, nose and throat*		$\sqrt{}$	√	√
Gynecology**	√		√	
Hemodialysis**	√	V	V	V
Urology*		V	V	V
Vascular**	√	√	V	√

<sup>\*</sup>The 15% enhanced reimbursement for Blue Cross commercial will begin for select ear, nose and throat and urology procedures in the second guarter. We'll publish a provider alert when this goes into effect for Blue Cross commercial.

#### The lists of procedure codes are available within our provider portal. 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 Billing and Claims on the menu bar and then click Codes and Criteria.
- 6. Look for the section titled Procedure codes eligible for additional professional reimbursement when performed in ambulatory surgical facilities.

We'll continue to closely monitor our list of eligible procedure codes and adjust it based on provider input and other factors, including the effectiveness of the policy. Any other procedures not listed will be paid following our standard fee schedules.



<sup>\*\*</sup>The 15% enhanced reimbursement for these services went into effect in 2024.



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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)

Did you know that kidney disease affects 35.5 million American adults, but 90% of them don't know they have it? The HEDIS measure Kidney Health Evaluation for Patients with Diabetes (KED) was developed to improve kidney disease testing in people with diabetes, because diabetes is a key risk factor for developing kidney disease.

#### Tips to successfully close the KED gap

- Make sure to complete both the estimated glomerular filtration rate (eGFR) and urine albumin creatinine ratio (uACR). The uACR is identified by both a quantitative urine albumin test and a urine creatinine test completed less than four days apart.
- Avoid billing 82044 (semiquantitative urine albumin) as HEDIS no longer recognizes this code for closing the KED gap. Instead, use current procedural terminology (CPT) codes 82043 (quantitative urine albumin) and 82570 (urine creatinine) to close the uACR portion of the KED measure.
- The Check patient's coverage to ensure you're sending them to in-network labs for testing. This will ensure we receive the required documentation to close the KED gap. The KED measure can only be closed through claims and supplemental data that have passed audit.
- If your provider organization is approved, send your KED data electronically through supplemental data to close the KED quality gap.

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### 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

- Balloon Dilation of the Eustachian Tube (BDET)
- Blepharoplasty and repair of brow ptosis
- Continuous Passive Motion Machine (CPM)
- Cosmetic and reconstructive surgery
- Genetic testing-whole exome and whole genome sequencing for diagnosis of genetic disorders
- Germline genetic testing for gene variants associated with breast cancer in individuals at moderate and high breast cancer risk (e.g., CHEK2, ATM, BARD1)
- Laboratory tests post transplant (kidney, heart, and lung) and for heart failure
- Noninvasive techniques for the evaluation and monitoring of patients with chronic liver disease
- Oral surgery

- Positron Emission Tomography (PET) for oncologic conditions
- Tibial nerve stimulation
- Transplant heart/kidney
- Transplant heart/lung

#### Noncovered services

- Adjunct and stand-alone ultrasound for routine breast cancer screening
- Alternative physical therapy modalities-experimental/ investigational
- Cardiac contractility modulation (i.e., Optimizer Smart) for the treatment of heart failure
- Serologic genetic and molecular screening for colorectal cancer
- Tactile breast imaging

#### **Established**

- Digital breast tomosynthesis (3-D mammography)
- Gait modulation and rhythmic auditory stimulation system (i.e., InTandem™)
- Laser interstitial thermal therapy
- Renal denervation for uncontrolled hypertension

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- Blue Cross, BCN no longer separately pay providers for services performed by bedside nurses, Page 50
- Blue Cross, BCN no longer separately pay providers for services performed by respiratory therapists, Page 51

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### We'll use updated ABA supplemental policy starting April 22

For dates of service on or after April 22, 2025, Blue Cross Behavioral Health<sup>SM</sup> will use the updated **Applied Behavioral Analysis (ABA) Supplemental Policy** when making determinations on prior authorization requests.

We made the following changes in the updated policy:

Caption	Subsection	Cignificant shanges
Section	Subsection	Significant changes
Initial Coverage	Diagnosis	Reformatted to make the diagnostic criteria easier to use and review
Criteria		Updated the list of specific diagnostic instruments to be used to determine autism spectrum disorder, or ASD, diagnosis and level of severity
	Initial Treatment	Reformatted the subsection (previously named <i>Treatment</i> ) to make it easier to use and review initial treatment criteria
		Added specific requirements for frequency and duration of caregiver involvement or parent or caregiver training (minimum two hours per month)
		Added specific requirements for supervision of direct treatment staff (minimum of 5% of direct hours)
Evaluation	Treatment	Expanded to include:
and Treatment Criteria		More detailed guidelines on continued ABA treatment
ontona		Alternate services that may be more appropriate for members and their families who are making progress, such as individual outpatient psychotherapy or cognitive behavioral therapy or family therapy
	Continued Treatment	Expanded to:
		Include steps to assist pediatric members in transitioning to adulthood
		Outline expectations for adjustment of treatment plans in response to member improvement or lack thereof

Blue Cross Behavioral Health manages prior authorization for behavioral health services for:

- Blue Cross Blue Shield of Michigan commercial members
- Medicare Plus Blue<sup>SM</sup> PPO members
- Blue Care Network commercial members
- BCN Advantage<sup>SM</sup> members

To view the updated policy, see the Behavioral Health Services section on either of the following webpages on bcbsm.com:

- For commercial members: Services That Need Prior Authorization
- For Medicare Advantage members: Medicare Advantage Prior Authorization

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### 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 are not 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.

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### 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.

### Pharmacy news roundup

Here's a summary of pharmacy-related provider alerts from January to February 2025..

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

#### February 2025

Changes to the management of oncology medical benefit drugs starting June 1 (PDF)

Changes to the Oncology Value Management program starting April 1 (PDF)

Tyenne will be preferred tocilizumab biosimilar product for most commercial members, starting June 1 (PDF)

Alyglo, Amtagvi and Loqtorzi to have requirements for Blue Cross commercial URMBT members starting June 1 (PDF)

Xbryk and Ospomyv to require prior authorization for most commercial members starting Feb. 28 (PDF)

Update: Step therapy won't be required for Darzalex Faspro (PDF)

How to obtain CGM products for commercial and Medicare Advantage members (PDF)

Rebyota and Ryoncil will have additional requirements for most commercial members starting March 31 (PDF)

Trazimera to be preferred trastuzumab product for Medicare Advantage members starting May 12 (PDF)

Avtozma to require prior authorization for most commercial members starting Feb. 20 (PDF)

Ahzantive, Enzeevu, Epysqli and Pavblu to require prior authorization for Medicare Advantage members starting May 1 (PDF)

Step therapy requirements added for Entyvio, Rystiggo, Vabysmo and Vyvgart for Medicare Advantage members starting May 1 (PDF)

Update: Piasky and Tremfya to have a site-of-care requirement for most commercial members starting June 1 (PDF)

#### January 2025

Some continuous glucose monitoring products available through participating network pharmacies for commercial members (PDF)

Evenity to have additional step therapy requirements for Medicare Advantage members starting May 1 (PDF)

We're changing how we manage Stelara and Stelara biosimilar therapies for most commercial members, starting April 1 and May 1 (PDF)

Updated: Simlandi preferred adalimumab product for Blue Cross, BCN commercial members (PDF)

Additional drugs to have requirements for Blue Cross commercial URMBT members starting April 16 (PDF)

How to enter subscriber/enrollee IDs when submitting electronic prior authorization requests for pharmacy benefit drugs (PDF)

Alhemo to require prior authorization for most commercial members starting Jan. 16 (PDF)

Commercial prior authorization requests submitted through NovoLogix must be submitted through a different application starting April 1 (PDF)

Ryoncil to require prior authorization for most members (PDF)

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# Medicare Advantage prior authorization requests submitted through NovoLogix must be submitted through a different application, starting July 1

Starting July 1, 2025, health care providers will need to submit prior authorization requests for medical benefit drugs that are currently submitted using the NovoLogix® online tool through a different application. This applies to Medicare Plus Blue<sup>SM</sup> and BCN Advantage<sup>SM</sup> members.

The new application is called the Medical and Pharmacy Drug PA Portal. Providers will be able to access it through our provider portal, Availity Essentials<sup>TM</sup>.

Blue Cross Blue Shield of Michigan and Blue Care Network will continue to manage the prior authorization requirements for these drugs. Continue to submit these prior authorization requests through NovoLogix through June 30, 2025.

Watch for additional communications about training opportunities and resources for the application.

Note: We previously announced a similar change for commercial members. See the Jan. 3, 2025, provider alert for details.

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.

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### Announcing changes to management of oncology medical benefit drugs

We're adding more oncology medical benefit drugs to our Oncology Value Management program administered by OncoHealth. Starting June 1, health care providers should submit prior authorization requests to OncoHealth for the drugs mentioned below.

#### Notes:

- Some of these changes affect both commercial and Medicare Advantage members; other changes affect only commercial members.
- These updates apply only to members who have requirements under the Oncology Value Management program.

#### Requirements for new drugs – for commercial and Medicare Advantage members

For dates of service on or after June 1, the drugs listed below will have requirements for Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue<sup>SM</sup>, Blue Care Network commercial and BCN Advantage<sup>SM</sup> members.

Note: Site-of-care requirements apply only to commercial members.

Brand name	Generic name HCPCS code	HCPCS code	Requirement	
Diana name		<b>Prior authorization</b>	Site of care**	
Tecentriq Hybreza™	Atezolizumab and hyaluronidase-tqjs	J9024	✓	✓
Lymphir™	Denileukin diftitox-cxdl	J9161	✓	
Anktiva®	Nogapendekin alfa inbakicept-pmln	J9028	✓	
Imdelltra™	Tarlatamab-dlle	J9026	✓	

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#### Changes to requirements

For dates of service on or after June 1, providers will need to submit prior authorization requests through OncoHealth for the drugs listed below. The drugs will be managed under the Oncology Value Management program.

Currently, providers submit prior authorization requests for these drugs through the NovoLogix® online tool, unless otherwise noted.

#### For commercial and Medicare Advantage members

Starting June 1, prior authorization requests for the following drugs will be managed by OncoHealth for both commercial and Medicare Advantage members.

Drug	Requirements	
Hercessi™ (trastuzumab-strf), HCPCS code Q5146	<b>Commercial</b> : Hercessi continues to require prior authorization. We're adding a site-of-care requirement.	
HCFC3 code Q5146	Medicare Advantage: We're adding a prior authorization requirement.	
Niktimvo™ (axatilimab-csfr), HCPCS code J9038	Already requires prior authorization for both commercial and Medicare Advantage members.	
Nypozi™ (filgrastim-txid), HCPCS	Commercial: Already has a prior authorization requirement.	
code Q5148	Medicare Advantage: We're adding a prior authorization requirement.	
Rytelo™ (imetelstat), HCPCS code J0870	Already requires prior authorization for both commercial and Medicare Advantage members.	

#### For commercial members only

Starting June 1, prior authorizations for the following drugs will be managed by OncoHealth for commercial members. (Currently, providers submit prior authorization requests for these drugs through the NovoLogix online tool.)

Note: For Medicare Advantage members, these drugs are already managed by OncoHealth.

Drand name	Generic name	HCPCS code	Requirement	
Brand name	Generic name		Prior authorization	Site of care**
Avastin®	Bevacizumab	J9035	✓	✓
Vegzelma®	Bevacizumab-adcd	Q5129	✓	✓
Alymsys <sup>®</sup>	Bevacizumab-maly	Q5126	✓	✓
Ryzneuta®	Efbemalenograstim alfa-vuxw	J9361	✓	
Rolvedon®	Eflapegrastim-xnst	J1449	✓	
Neupogen®	Filgrastim	J1442	✓	
Releuko®	Filgrastim-ayow	Q5125	✓	

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Brand name	Generic name	HCPCS code	Requirement	
			Prior authorization	Site of care**
Neulasta®	Pegfilgrastim	J2506	✓	
Ziextenzo <sup>®</sup>	Pegfilgrastim-bmez	Q5120	✓	
Stimufend®	Pegfilgrastim-fpgk	Q5127	✓	
Fylnetra®	Pegfilgrastim-pbbk	Q5130	✓	
Granix <sup>®</sup>	Tbo-filgrastim	J1447	✓	
Herceptin <sup>®</sup>	Trastuzumab	J9355	✓	✓
Ontruzant®	Trastuzumab-dttb	Q5112	✓	✓
Trazimera™	Trastuzumab-gyyp	Q5116	✓	✓
Herzuma®	Trastuzumab-pkrb	Q5113	✓	✓

#### Courses of treatment that start before June 1 and continue beyond June 1

Commercial members who have authorizations that were approved before June 1 for the drugs discussed above can continue to receive therapy until their authorizations expire.

Prior authorization is required through OncoHealth only if there's a change to the treatment plan on or after June 1, or if treatment with the drug extends beyond the authorization end date.

#### Removal of prior authorization requirement – for commercial members only

For dates of service on or after June 1, Avzivi® (bevacizumab-tnjn), won't require prior authorization for Blue Cross commercial or BCN commercial members.

Note: To determine the requirement for Avzivi for Medicare Advantage members, see the Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members.

#### Additional information

For more information about the Oncology Value Management program, including information about the members who have requirements under the program and how to submit requests to OncoHealth, see the Oncology Value

Management program through OncoHealth: FAQs for providers and the following pages on ereferrals.bcbsm.com:

- Blue Cross Medical Benefit Drugs
- BCN Medical Benefit Drugs

\*For commercial members, 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; or an ambulatory infusion center. Site-of-care requirements don't apply to Medicare 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.

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

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### Changes to Oncology Value Management program effective April 1

As we previously announced, oncology pharmacy benefit drugs are managed through our Oncology Value Management program, effective April 1, 2025. Health care providers can submit prior authorization requests for these drugs to OncoHealth, which administers the Oncology Value Management program.

Prior to April 1, only oncology medical benefit drugs were managed through the Oncology Value Management program. Adding oncology **pharmacy** benefit drugs to the program:

- Affects prior authorization requests for oncology pharmacy benefit drugs for all Blue Cross Blue Shield of Michigan commercial, Medicare Plus Blue<sup>SM</sup>, Blue Care Network commercial and BCN Advantage<sup>SM</sup> members whose coverage includes a pharmacy benefit
- Enables health care providers to submit a single prior authorization request for a patient's entire drug regimen

   for both oncology medical benefit drugs and oncology pharmacy benefit drugs

When requesting prior authorization, OncoHealth requires that providers submit the entire drug regimen to determine medical necessity. This means providers must include all drugs in the request – those that require prior authorization and those that don't.

In addition, while reviewing clinical documentation, OncoHealth may add to the request any drugs that weren't requested, to capture the entire regimen.

#### Check member benefits

With the April 1 expansion of the Oncology Value Management program, prior authorization requirements changed for some commercial members. This is because some members whose employer groups didn't participate in the Oncology Value Management program prior to April 1 have requirements under the program for dates of service on or after April 1.

As always, be sure to check benefits for all members before providing services.

#### **Drug lists**

We've updated the following drug lists to specify the oncology pharmacy benefit drugs that require prior authorization through OncoHealth.

- For commercial members:
  - Drug lists on the For Providers: Drug Lists page on bcbsm.com
- For Medicare Advantage members:
  - Drug lists on the 2025 Drug Lists for Medicare Members page on bcbsm.com

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### Where to find the authorization number to include on claims

When submitting claims, include the nine-digit OncoHealth authorization reference number, which is included on all OncoHealth approval letters. To locate the reference number in OncoHealth's OneUM™ portal:

- 1. Click on Provider Dashboard in the left navigation.
- 2. Click on Completed Assignments.
- 3. Select a completed case to view the case summary.

#### How to determine billable units for a drug

OncoHealth approves drug regimens based on dose, frequency and duration of the authorization. While billable units aren't displayed in the OneUM portal, providers can see the approved number of cycles and frequency within the case summary.

To find this information in OncoHealth's OneUM portal:

- 1. Click on Provider Dashboard in the left navigation.
- 2. Click on Completed Assignments.
- 3. Select a completed case to view the case summary.

## Availability of providers in OncoHealth's OneUM portal

If provider offices are unable to submit a prior authorization request through the OncoHealth OneUM portal because the ordering provider isn't listed in the portal, email the OncoHealth Client Support Team at clientsupport@oncohealth.us. The team will add the provider.

### Courses of treatment that start before April 1 and continue beyond April 1

Members who start receiving oncology pharmacy benefit drugs before April 1 can continue to receive those drugs under their approved authorization until it expires.

Prior authorization is required through OncoHealth only if there's a change to the treatment plan on or after April 1, or if treatment with the drug extends beyond the authorization end date.

#### Recorded training

Providers who didn't attend an OncoHealth provider training session or would like a refresher on the submission process can watch the recorded *OncoHealth* presentation on our Provider Training site.

To access the recorded training:

- 1. Log in to our provider portal at 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 on the *Applications* tab.
- 4. Click on Submit.
- 5. Search Oncology, and then click OncoHealth presentation.
- 6. Click on Launch for one of the learning activities.

If you need help with accessing or navigating the site, email **ProviderTraining@bcbsm.com**.

#### Additional information

We've updated the Oncology Value Management program through OncoHealth: FAQs for providers document to reflect the information in this alert.

If you have issues while working in OncoHealth's OneUM portal, email the OncoHealth Client Support Team at clientsupport@oncohealth.us.

As a reminder, prior authorization requests for oncology pharmacy benefit drugs are currently submitted through an electronic prior authorization tool, such as CoverMyMeds®, and are managed by the Blue Cross and BCN pharmacy departments.

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We're changing how we communicate medical policy changes for medical benefit drugs that require prior authorization for commercial members

Currently, we publish provider alerts to announce medical policy changes for medical benefit drugs that require prior authorization for Blue Cross Blue Shield of Michigan and Blue Care Network commercial members.

Effective immediately, we'll publish these changes in a new document titled Changes to medical necessity criteria for prior authorizations for medical benefit drugs. When there are medical policy changes that affect prior authorization requirements, we'll update the document to include:

- The changes to the medical necessity criteria
- The date when the changes were approved by the Pharmacy and Therapeutics Committee
- The date the changes go into effect

Check the document regularly for the latest information about these changes.

### Piasky, Tremfya to have siteof-care requirement for most commercial members, starting June 1

For dates of service on or after June 1, 2025, we're adding a site-of-care requirement for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under medical benefits:

- Piasky® IV and SC (crovalimab-akkz), HCPCS code J1307
- Tremfya® IV and SC (guselkumab), HCPCS code J1628



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When you submit prior authorization requests for these drugs, you'll be prompted to select a site of care. 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 Piasky or Tremfya in an outpatient hospital setting.

Please remember, 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 Piasky or Tremfya before June 1, 2025, will be able to continue receiving these drugs in their current locations until their existing authorizations expire. If these members then continue treatment under new prior authorizations, the site-of-care requirement outlined above will apply.

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

Prior authorization and site-of-care requirements apply only to Blue Cross commercial 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.

While UAW Retiree Medical Benefits Trust non-Medicare members don't participate in the standard prior authorization program, these requirements apply to them.

Note: These requirements don't apply to Blue Cross and Blue Shield Federal Employee Program® members.

#### Lists of requirements

For more information about requirements related to drugs covered under medical benefits, see these lists:

- Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members
- Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare members We'll update these lists before the effective date.

You can access these lists 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

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

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# Ahzantive, Enzeevu, Epysqli, Pavblu to require prior authorization for Medicare Advantage members, starting May 1

For dates of service on or after May 1, 2025, the following drugs will require prior authorization for Medicare Plus Blue<sup>SM</sup> and BCN Advantage<sup>SM</sup> members:

- Ahzantive® (aflibercept-mrbb), HCPCS code Q5150
- Enzeevu™ (aflibercept-abzv), HCPCS code Q5149
- Epysqli® (eculizumab-aagh), HCPCS code Q5151
- Pavblu™ (aflibercept-ayyh), HCPCS code Q5147

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 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
- Electronically through an 837I transaction or using the UB04 claim for a hospital outpatient type of bill 013X

### How to access NovoLogix

To access NovoLogix, log in to our provider portal at availity.com, click on *Payer Spaces* in the menu bar, 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 For Providers: Register for Web Tools page 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 before the effective date.

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.

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### Trazimera to be preferred trastuzumab product for Medicare Advantage members, starting May 12

Preferred and nonpreferred trastuzumab products are changing for Medicare Plus Blue and BCN Advantage members for dates of service on or after May 12, 2025.

The preferred trastuzumab product will be Trazimera® (trastuzumab-qyyp), HCPCS code Q5116.

Providers will have to show that our Medicare Advantage members have tried and failed Trazimera when requesting prior authorization for the following nonpreferred drugs:

- Herceptin® (trastuzumab), HCPCS code J9355
- Herceptin Hylecta<sup>TM</sup> (trastuzumab and hyaluronidaseoysk), HCPCS code J9356
- Ontruzant® (trastuzumab-dttb), HCPCS code Q5112
- Herzuma® (trastuzumab-pkrb), HCPCS code Q5113
- Oqivri® (trastuzumab-dkst), HCPCS code Q5114
- Kanjinti® (trastuzumab-anns), HCPCS code Q5117

Trazimera will continue to require prior authorization.

Submit prior authorization requests to OncoHealth 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
- Electronically through an 837I transaction or using the UB04 claim for a hospital outpatient type of bill 013X

#### How to submit prior authorization requests

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

- Through the OncoHealth OneUM™ portal, which you can access by logging in to our provider portal at availity.com, clicking on Payer Spaces, and then clicking on the BCBSM and BCN logo. Click on the OncoHealth Provider Portal tile in the Applications tab.
- By calling OncoHealth at 1-888-916-2616
- By faxing to OncoHealth at 1-800-264-6128

#### 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 prior to the effective date.

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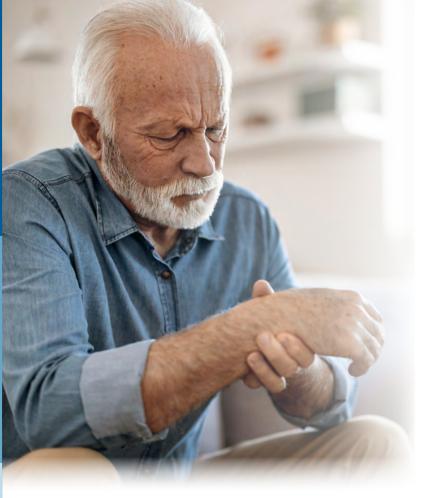
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Update: Tyenne will be preferred tocilizumab biosimilar product for most commercial members, starting June 1

On Feb. 27, 2025, we published a provider alert that didn't mention the information that has been changed under the "How this will affect members under the medical benefit" section. We've updated this provider alert to show how Tyenne IV will be covered under the medical benefit for most Blue Cross and BCN group commercial members for dates of service on or after June 1, 2025. Under the "How to submit prior authorization requests" section, the prior authorization portal to submit

requests has been updated to "Medical/Pharm Drug Benefit Prior Auth (Commercial)".

We will change how we manage Actemra® and Actemra biosimilar products, starting June 1, 2025. This change will affect most Blue Cross and BCN commercial members under pharmacy and medical benefits.

### How this will affect members under pharmacy benefits

Actemra (tocilizumab) subcutaneous, or SC, injection will no longer be covered for all commercial fully insured and self-funded groups using the Custom, Custom Select and Clinical drug lists. Tyenne® (tocilizumab-aazg) will be the preferred (tocilizumab) biosimilar product.

Authorizations for Actemra will remain in effect until May 31, 2025. If members decide to use Actemra on or after June 1, they'll be responsible for the full cost. New authorizations for Tyenne SC will be approved June 1, 2025, and active through May 31, 2026, so members can continue therapy without interruption.

Members on a plan using the Preferred Drug List are excluded from this change. This change doesn't apply to Medicare Advantage groups or members.

### Filling the prescription

We'll only pay for Tyenne when filled through Walgreens Specialty Pharmacy, an independent company that provides specialty pharmacy services to Blue Cross and BCN.

Members who are currently filling their Actemra SC prescriptions at the Michigan Medicine Specialty Pharmacy may continue filling there.

### If members are currently filling Actemra SC through Walgreens Specialty Pharmacy:

- Walgreens Specialty Pharmacy will obtain a new prescription for Tyenne SC from their doctor, if needed.
- Walgreens Specialty Pharmacy will fill the prescription with Tyenne SC starting April 1.

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#### If members are currently filling their prescriptions through a pharmacy other than those mentioned above:

- Walgreens Specialty Pharmacy will send affected members a welcome letter. The letter will include the pharmacy phone number.
- A representative from Walgreens Specialty Pharmacy will be calling the member to set up a profile.
- Walgreens Specialty Pharmacy will obtain a new prescription for Tyenne SC from their doctor.

Prescribers can send a new prescription for Tyenne SC by one of the following methods:

Pharmacy	Methods
Walgreens Specialty	Fax: 1-866-515-1356
Pharmacy	E-prescribing name: Walgreens Specialty Pharmacy – MICHIGAN
	Contact number: 1-866-515-1355
Michigan Medicine	Prescriber Fax: 734-232-3408
Specialty Pharmacy	E-prescribing name: UM SPECIALTY HOME DELIVERY PHARMACY
	Address: 7300 West Joy Road; Dexter, MI 48130
	Contact number: 1-855-276-3002

#### How this will affect members under medical benefits

For dates of service on or after June 1, 2025, Tyenne® (tocilizumab-aazg), HCPCS code Q5135 will be the preferred tocilizumab biosimilar product.

The nonpreferred tocilizumab products are Tofidence<sup>TM</sup> Avtozma $^{\oplus}$  and Actemra $^{\oplus}$ .

 Members who have active authorizations for the IV (intravenous) formulation of Tyenne won't be affected by this change.

- For members who have active authorizations for a nonpreferred IV tocilizumab product:
- These members are authorized to continue their current therapy under the medical benefit through May 31, 2025.
- We're proactively issuing authorizations for Tyenne IV under the medical benefit from June 1, 2025, to May 31, 2026, to avoid any interruptions in care.
- For members who have active authorizations for Tyenne SC or a nonpreferred SC tocilizumab product:
  - These members are authorized to continue their current therapy under the medical benefit through May 31, 2025.
  - We're proactively issuing authorizations for Tyenne SC under the pharmacy benefit from June 1, 2025, to May 31, 2026, to avoid any interruptions in care.
- Proactive authorizations for preferred therapy under the pharmacy benefit will be issued only for members who have their pharmacy benefit through Blue Cross Blue Shield of Michigan or Blue Care Network.
- Members that don't have prescription coverage through Blue Cross or BCN and are currently filling their prescription through their medical benefit, will need a new prescription with a prior authorization through their pharmacy provider.

To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

### How to submit prior authorization requests

Submit medical and pharmacy prior authorization requests through the Medical and Pharmacy Drug PA Portal, which you can access by clicking the *Medical/Pharm Drug Benefit Prior Auth (Commercial)* tile in our provider portal (availity.com). You can also submit pharmacy benefit drugs prior authorization requests using CoverMyMeds®.

Walgreens Specialty Pharmacy is an independent company that provides specialty pharmacy services covered under the pharmacy benefit for various Blue Cross Blue Shield of Michigan and Blue Care Network members with commercial plans.

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We're changing how we manage Stelara and Stelara biosimilar therapies for most commercial members, starting April 1 and May 1

Yesintek<sup>™</sup> (ustekinumab-kfce) will be the preferred ustekinumab product for most commercial members, as follows:

- When covered under the **pharmacy benefit**, this change will be effective for dates of service on or after April 1, 2025.
- When covered under the **medical benefit**, this change will be effective for dates of service on or after May 1, 2025.

Members on a plan using the Preferred Drug List are excluded from this change. This change doesn't apply to Medicare Advantage groups or members.

In addition, for dates of service on or after May 1, 2025, the subcutaneous, or SC, formulations of ustekinumab will no longer be payable under the member's medical benefit. Members who continue to receive SC ustekinumab administered by a health care provider (billed under the medical benefit) on or after May 1 may be responsible for the full cost.

### How this will affect members under the pharmacy benefit

Authorizations for Stelara SC, brand ustekinumab, will remain in effect until March 31, 2025. New authorizations for Yesintek SC will be approved April 1, 2025, and active through March 31, 2026, so members can continue therapy without interruption. If members decide to use Stelara SC on or after April 1, they'll be responsible for the full cost.

#### Filling the prescription

We'll only pay for Yesintek SC when filled through Walgreens Specialty Pharmacy, an independent company that provides specialty pharmacy services to Blue Cross and BCN.

However, some members may be currently filling their Stelara SC prescriptions at the Michigan Medicine Specialty Pharmacy. We'll pay for Yesintek SC when filled at that pharmacy to allow those members to continue receiving this medication there.

The contact information is below.

### If members are currently filling Stelara SC through Walgreens

Walgreens Specialty Pharmacy will obtain a new prescription for Yesintek SC from their doctor, if needed.

Walgreens Specialty Pharmacy will fill the prescription with Yesintek SC on or after April 1.

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#### If members are currently filling their prescriptions through a pharmacy other than those mentioned above

A representative from Walgreens Specialty Pharmacy will be calling the member to set up a profile.

Walgreens Specialty Pharmacy will obtain a new prescription for Yesintek SC from their doctor.

Prescribers can send a new prescription for Yesintek SC by one of the following methods:

Pharmacy	Methods		
Walgreens	Fax: 1-866-515-1356		
Specialty Pharmacy	E-prescribing name: Walgreens Specialty Pharmacy – MICHIGAN		
	Contact number: 1-866-515-1355		
Michigan	Prescriber Fax: 734-232-3408		
Medicine Specialty Pharmacy	E-prescribing name: UM SPECIALTY HOME DELIVERY PHARMACY		
	Address: 7300 West Joy Road; Dexter, MI 48130		
	Contact number is 1-855-276-3002		

### How this will affect members under the medical benefit

The nonpreferred ustekinumab products are Imuldosa™, Otulfi™, Pyzchiva®, Selarsdi™, Stelara®, Steqeyma® and Wezlana™.

Members who have active authorizations for the IV formulation of Yesintek won't be affected by this change.

For members who have active authorizations for a nonpreferred ustekinumab product or SC ustekinumab product: These members are authorized to continue their current therapy under the medical benefit through April 30, 2025.

We're proactively issuing authorizations for Yesintek SC under the pharmacy benefit from May 1, 2025, to April 30, 2026, to avoid any interruptions in care.

- Proactive authorizations for preferred therapy under the pharmacy benefit will be issued only for members who have their pharmacy benefit through Blue Cross Blue Shield of Michigan or Blue Care Network.
- Members that don't have prescription coverage through Blue Cross or BCN and are currently filling their prescription through their medical benefit, will need a new prescription with a prior authorization through their pharmacy provider.

To determine whether a group participates in the prior authorization program, see the Specialty Pharmacy Prior Authorization Master Opt-in/out Group list.

#### How to submit prior authorization requests

For a self-administered ustekinumab SC product (covered under the pharmacy benefit), submit the request using an electronic prior authorization, or ePA, tool such as CoverMyMeds® or Surescripts®.

For an ustekinumab IV product that requires administration by a health care provider (covered under the medical benefit), submit the request through the NovoLogix® online tool.

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

Walgreens Specialty Pharmacy is an independent company that provides specialty pharmacy services covered under the pharmacy benefit for various Blue Cross Blue Shield of Michigan and Blue Care Network members with commercial plans.

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# Update: Commercial prior authorization requests submitted through NovoLogix must be submitted through a different application, starting April 21

For most commercial members, health care providers will need to submit prior authorization requests for medical benefit drugs that are currently submitted through the NovoLogix® online tool through a different application. We announced this change in a Jan. 3 provider alert.

The name of the new application is **Medical and Pharmacy Drug PA Portal**. You'll be able to access it starting April 21, 2025 to submit both medical and pharmacy drug prior authorization requests for commercial members.\*

#### To access it:

- 1. Log in to our provider portal at availity.com.
- 2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
- 3. Click the Medical/Pharm Drug Benefit Prior Auth (Commercial) tile in the Applications tab.

#### Notes:

- Submit any retroactive authorization requests through the new tool.
- The NovoLogix online tool will be available until May 1, 2025.
- Starting April 21, The Medication PriorAuth (pharmacy benefit) tile you used to access to submit prior authorization requests for most pharmacy benefit drugs will be renamed to Pharmacy Drug Prior Auth Only (Nonpreferred).
- We previously communicated that this change would happen on April 1.

### Training opportunity

A demo of the new application is available on our Provider Training site. To find it, search on *prior authorization*. The name of the demo is *Medical and Pharmacy Drug PA Portal Overview*.

#### How to access the Provider Training site

To access the training site, follow these steps:

- 1. Log in to the provider portal at availity.com.
- 2. Click *Payer Spaces* on 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.

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

\*Submit prior authorization requests for oncology medical and pharmacy benefit drugs to OncoHealth. For more information, see the document titled Oncology Value Management program through OncoHealth: FAQ for providers.

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



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

- What you need to know about doing business with Blue Cross, Page 1
- Provider portal pointers: Eligibility and benefits, Page 9
- Use new telemedicine codes, starting July 1, 2025, Page 45

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### How to appeal Cotiviti's DRG cross-claim clinical reviews

Cotiviti, an independent company that provides claim reviews for Blue Cross Blue Shield of Michigan and Blue Care Network, is conducting diagnosis-related group cross-claim clinical reviews, or CCCRs, for Medicare Plus Blue<sup>SM</sup> and BCN Advantage<sup>SM</sup> inpatient claims. The reviews will focus on the member's episode of care as explained in a March 2024 article in *The Record*.

#### Initial review and notification

Cotiviti selects claims to review without medical records. If Cotiviti identifies an adjustment opportunity, it will notify health care providers by mail. If you disagree with Cotiviti's decision, you have 50 calendar days to submit a written appeal request.

#### Appeals process

Submit written appeal requests through Cotiviti's Provider Connection Portal or refer to your audit finding letter for the mail or fax addresses.

- First-level reconsideration: Submit a written request within 50 days of the date on your audit finding letter. **Include all relevant medical records with the first-level appeal request coversheet**. Don't submit medical records separately.
- Second-level appeal: If necessary, submit a written request to Cotiviti within 20 days after the first-level appeal results for an external review by Physician's Review Organization, an accredited independent medical review organization.

If you have questions, contact Cotiviti Provider Relations at **770-379-2009** from 8 a.m. to 5 p.m. Eastern time, Monday through Friday.

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# Use new telemedicine codes, starting July 1, 2025

Blue Cross Blue Shield of Michigan commercial and Blue Care Network commercial will require claims for virtual evaluation and management, or E/M, services to be submitted using new telemedicine procedure codes \*98000 through \*98015, effective July 1, 2025.

Continue to use the telemedicine place of service codes 02 or 10. The telemedicine modifiers aren't required for the new telemedicine E/M procedure codes.



If rendering a virtual E/M service that's audio-only or audio-video, don't submit claims for these services using E/M procedure codes \*99202 through \*99205 or \*99212 through \*99215 with the telemedicine place of service codes or modifiers. The claims processing systems will be updated to deny these E/M codes when billed with any telemedicine place of service or modifiers as provider liable.

The reimbursement amounts for the telemedicine E/M procedure codes \*98000 through \*98015 and the other outpatient visit E/M procedure codes \*99202 through \*99205 and \*99212 through \*99215 are available in the provider portal.

#### Telemedicine synchronous audio-video codes

New tel	emedicine E/M codes, effective July 1, 2025	Do not use these codes for telemedicine services		
Code	Description	Code	Description	
*98000	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	*99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/ or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	
*98001	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	*99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	

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New tel	emedicine E/M codes, effective July 1, 2025	Do not	use these codes for telemedicine services
Code	Description	Code	Description
*98002	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/ or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	*99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.
*98003	Synchronous audio-video visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	*99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
*98004	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	*99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
*98005	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	*99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
*98006	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	*99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

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New telemedicine E/M codes, effective July 1, 2025			Do not use these codes for telemedicine services		
Code	Description	Code	Description		
*98007	Synchronous audio-video visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	*99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.		

### Telemedicine synchronous audio-only codes

New tel	emedicine E/M codes, effective July 1, 2025	Do not i	use these codes for telemedicine services
Code	Description	Code	Description
*98008	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	*99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/ or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.
*98009	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	*99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
*98010	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.	*99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/ or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

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New tel	emedicine E/M codes, effective July 1, 2025	Do not	use these codes for telemedicine services
Code	Description	Code	Description
*98011	Synchronous audio-only visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	*99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.
*98012	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 10 minutes must be exceeded.	*99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.
*98013	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, low medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	*99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.
*98014	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, moderate medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	*99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.
*98015	Synchronous audio-only visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination, high medical decision making, and more than 10 minutes of medical discussion. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	*99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

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#### Frequently asked questions

Q: Will claims be denied if non-virtual E/M codes are billed using telemedicine place of service codes and modifiers?

**A**: Effective July 1, 2025, Blue Cross and BCN claims processing systems will be updated to reject the non-virtual E/M codes when billed with the telemedicine place of service and modifiers as provider liable.

Q: Will Blue Cross limit virtual services to the use of the new telemedicine E/M procedure codes only?

**A**: No. There are other procedure codes that identify telemedicine services that aren't for an E/M visit. These services are still allowed. For example, Asynchronous/Store and Forward procedure codes.

**Q**: What about the other procedure codes that are billed for telemedicine services that aren't for an E/M procedure code?

**A**: This telemedicine update only applies to E/M procedure codes. According to the American Medical Association coding guidelines, these codes are specific to E/M visits that are rendered synchronous (real time) through audio-video and audio-only.

**Q**: Have prior provider communications for these new codes been released?

**A**: Yes. We introduced the new telemedicine procedure codes as payable, effective Jan. 1, 2025, in the 2025 CPT and HCPCS Update document, which we communicated in the **February 2025** Record. Additional communications will be posted in our provider portal, Availity Essentials<sup>TM</sup>, and BCN Provider News.

**Q**: What is the difference in the reimbursement of the current E/M procedure codes and the new telemedicine E/M procedure codes for the Centers for Medicare & Medicaid Services?

**A**: Currently, CMS doesn't allow for the reimbursement of the new telemedicine E/M procedure codes. The reimbursement amounts for the new telemedicine procedure codes for Blue Cross and BCN are available in the provider portal.

**Q**: Will Blue Cross reimburse both the new telemedicine E/M procedure codes and the office and outpatient E/M procedure codes?

**A**: Yes. Blue Cross and BCN will continue to reimburse both the office and outpatient and telemedicine E/M procedure codes. However, effective July 1, 2025, Blue Cross and BCN will only reimburse virtual E/M services using the new telemedicine E/M codes. If a virtual service is reported with the office and outpatient codes \*99202-\*99205 or \*99212-\*99215, the claim will reject and a resubmission will be required.

**Q**: Will the new telemedicine E/M codes requirement align with current Blue Cross and BCN Telemedicine Services Medical Policy?

**A**: Yes. The Telemedicine Medical Policy lists the medical criteria for a virtual visit along with the inclusion and exclusion guidelines for telemedicine services.

**Q**. What is the HMO authorization requirement for telemedicine services for BCN?

**A**: The authorization requirement for E/M services is referral. A referral will be required when an E/M service is **not** provided by the primary care provider.

Q: Does Blue Cross and BCN cover procedure code \*98016?

A: Yes. Procedure code \*98016 is payable.

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### Blue Cross, BCN no longer separately pay providers for services performed by bedside nurses

Effective March 1, 2025, Blue Cross Blue Shield of Michigan and Blue Care Network no longer separately pays health care providers on inpatient facility claims for services performed by a bedside nurse. This policy currently only applies to inpatient facility claims that are eligible for a catastrophic cost outlier payment and where Blue Cross or BCN reviews the medical record and itemized bill.

Our updated payment policy isn't intended to affect decision-making for patient care, and health care providers are expected to apply independent medical judgment when caring for all members. This policy applies to inpatient facility claims that meet the above criteria submitted for Blue Cross and BCN commercial members.

### Background

Nursing services are prescribed by a physician or nonphysician practitioner for the assessment, treatment and monitoring of patients. This policy pertains to all services performed by a bedside nurse in all prescribed settings (for example, emergency room, regular room and board, intensive care unit or operating room).

#### Policy

The following list provides examples of nursing services that aren't separately payable on inpatient facility claims when performed by a bedside nurse, as they are inclusive to the room and board, treatment area or lab. This list is not an all-inclusive list.

- Administration of any medicine, chemotherapy, IV fluid, nebulizer or inhaler
- Arterial, capillary or venous blood draw
- Assessments
- Assisting with bedside procedures
- Insert, discontinue or maintain IV lines
- Insert, discontinue or maintain urinary catheter
- Newborn care
- Ostomy care
- Patient and family education
- Suctioning
- Trach care and changing of cannula
- Vascular access device or arterial line blood draw
- Wound care
- Monitoring when billed on the same date of service as an intermediate ICU or ICU room and board charge. Types of monitoring includes:
  - Pulse oximeters
  - Arterial lines or readings
  - Transcutaneous monitoring
  - End-tidal CO2 monitoring
  - Central venous pressure, or CVP lines
  - Swan-Ganz catheters or pressure reading
  - Cardiac output
  - Pulmonary artery pressure

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### Blue Cross, BCN no longer separately pay providers for services performed by respiratory therapists

Effective March 1, 2025, Blue Cross Blue Shield of Michigan and Blue Care Network no longer separately pays health care providers for services performed by respiratory therapists on inpatient facility claims. This policy currently only applies to inpatient facility claims that are eligible for a catastrophic cost outlier payment and where Blue Cross or BCN reviews the medical record and itemized bill.

This payment policy isn't intended to affect decisionmaking for care of the patient, and health care providers are expected to apply independent medical judgment when caring for all members. This policy applies to inpatient facility claims that meet the above criteria submitted for Blue Cross and BCN commercial members.

#### Background

Respiratory therapy services are services prescribed by a physician or a non-physician practitioner for the assessment and diagnostic evaluation, treatment, management and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function. This policy pertains to services performed by a respiratory therapist in all prescribed settings (for example, an emergency room, regular room and board, intensive care unit or operating room).

All respiratory services performed by a nurse are considered part of the room and board or treatment area.

#### **Policy**

The following list provides examples of respiratory therapy services that aren't separately payable on the inpatient facility claim, as they are inclusive to the respiratory modality, room and board, treatment area or laboratory. This list is not an all-inclusive list.

- Arterial line blood draw
- Assisting with bedside procedures



- Patient and family education
- Respiratory assessments
- Suctioning
- Tracheostomy care and changing of cannula
- Transport of patient
- Venous and capillary blood draw
- Arterial puncture when the patient is on a ventilator
- Monitoring when an Intermediate ICU or ICU room and board charge is billed on the same date:
  - Pulse oximeters
  - Arterial lines or readings
  - Transcutaneous monitoring
  - End-tidal CO2 monitoring
- Administration of nebulizers or inhalers when billed on the same date of service as a charge for CPAP, BiPAP, noninvasive ventilator or ventilator
- Chest physiotherapy (percussion, vibration, postural drainage or cough assist) when billed on the same date of service as a charge for CPAP, BiPAP, noninvasive ventilator or ventilator
- Therapeutic ventilatory maneuver (recruitment maneuver) when billed on the same date of service as a charge for CPAP, BiPAP, noninvasive ventilator or ventilator

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### 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:

- BCN Commercial
  - E/M services with modifier 25 denied in error
- BCN Advantage
  - E/M services with modifier 25 denied in error
  - Modifier JW and JZ

- Reconsideration requests related to clinical editing denials must be submitted through Availity starting June 1, 2025
- Reconsideration requests must include rationale for review
- Understanding QNT Denials for Echocardiograms



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

- What you need to know about doing business with Blue Cross, Page 1
- Provider portal pointers: Eligibility and benefits, Page 9
- Webinars for physicians, coders focus on documentation and coding, Page 12
- Professional reimbursement increased for select procedures performed in ambulatory surgical facilities, Page 23
- Quality Minute Kidney Health Evaluation for Patients with Diabetes (KED), Page 24
- Behavioral health providers shouldn't submit claims for behavioral health collaborative care services, Page 27
- Pharmacy news roundup, Page 28
- Update: Tyenne will be preferred tocilizumab biosimilar product for most commercial members, starting June 1, Page 39
- We're changing how we manage Stelara and Stelara biosimilar therapies for most commercial members, starting April 1 and May 1, Page 41

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# 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**.

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### We'll no longer require prior authorization for pain management procedures for Medicare Advantage members

In second-quarter 2025, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer require prior authorization for pain management procedures for Medicare Plus Blue<sup>SM</sup> and BCN Advantage<sup>SM</sup> members.

Any Medicare Advantage members who have active authorizations and receive pain management injections during this transition will continue to receive communications from TurningPoint Healthcare Solutions.

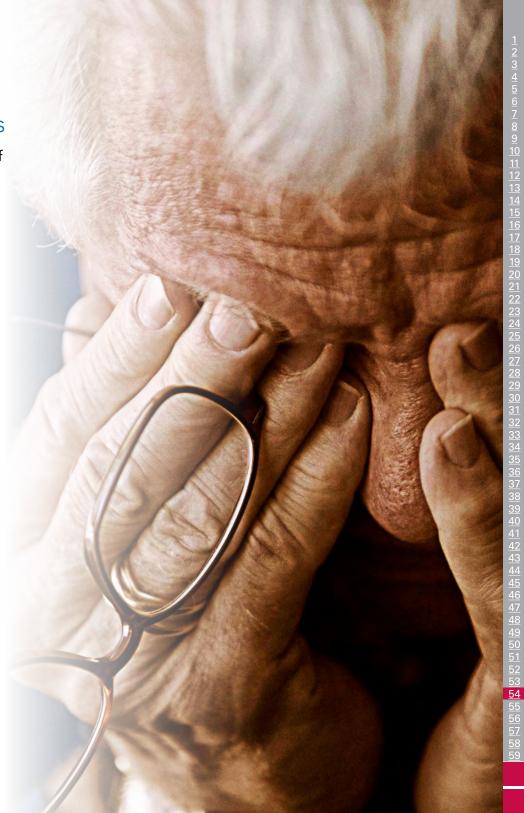
As part of our commitment to deliver care in line with standards set by the Centers for Medicare & Medicaid Services, we'll continue to monitor compliance with these standards through claims review, post-payment audits and strategic collaboration with health care providers who are in shared- and full-risk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

Watch our provider alerts and newsletter articles for additional information.

#### Notes:

- Health care providers must continue to request prior authorization from TurningPoint Health Care Solutions for Medicare Advantage members for orthopedic and spinal surgeries.
- There are no changes to prior authorization requirements through TurningPoint for Blue Cross and BCN commercial members. Prior authorization will continue to be required for orthopedic, pain management and spinal procedures.

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.



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# How to find out which procedure codes require prior authorization by TurningPoint

We've retired the Musculoskeletal procedure codes that require authorization by TurningPoint document. To determine which procedure codes require prior authorization, open Procedure codes for which providers must request prior authorization.

Here's what you need to know:

• To find procedure codes that require prior authorization by TurningPoint Healthcare Solutions, search for "TurningPoint" in the document. You can also search for a specific procedure code. • To learn more about the procedure code list, see the introductory information in the document.

This applies to the following lines of business:

- Blue Cross Blue Shield commercial
- Medicare Plus Blue<sup>SM</sup>
- Blue Care Network commercial
- BCN Advantage<sup>SM</sup>

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.

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### Questionnaire changes in e-referral system

On Feb. 2, 2025, and Feb. 23, 2025, we updated various questionnaires and deleted others in the e-referral system.

We've updated the Preview questionnaires and medical necessity criteria document on the ereferrals.bcbsm.com website to reflect these changes.

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.

#### Questionnaire updates

On Feb. 2, the following questionnaires were updated in the e-referral system.



Service	Affected lines of business	What happened prior to Feb. 2	What happened starting Feb. 2
Blepharoplasty	<ul><li>Medicare Plus Blue</li><li>BCN Advantage</li></ul>	A <b>custom</b> questionnaire opened in the e-referral system for procedure codes *15822, *15823, *67900, *67901, *67902, *67903, *67904, *67906 and *67908	We retired the <b>custom</b> questionnaire for Medicare Plus Blue and BCN Advantage.  The <b>standard</b> questionnaire, titled <i>Blepharoplasty and repair of brow ptosis</i> (outpatient), now opens in the e-referral system for the procedure codes listed in the column to the left.
Percutaneous left atrial appendage closure	<ul><li>Medicare Plus Blue</li><li>BCN commercial</li><li>BCN Advantage</li></ul>	A questionnaire opened in the e-referral system for procedure code *33340.	This service doesn't require prior authorization for Medicare Plus Blue, BCN commercial or BCN Advantage.

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On Feb. 23, the following questionnaire was updated in the e-referral system.

Questionnaire	Affected lines of business	What happened prior to Feb. 23	What happened starting Feb. 23
Oral surgery	<ul> <li>Blue Care Network commercial</li> <li>BCN Advantage</li> </ul>	A questionnaire opens when requesting prior authorization for procedure codes *40525, *40527, *40700, *40701, *40702, *40720, *40761, *40808, *40810, *40812, *40816, *40818, *40840, *40842, *40843, *40844, *40845, *40899, *41800, *41805, *41806, *41820, *41821, *41822, *41823, *41825, *41826, *41877, *41828, *41830, *41850, *41870, *41872, *41874, *42200, *42210, *42215, *42220 and *42225.	<ul> <li>For BCN commercial:</li> <li>The questionnaire will open for additional procedure codes: *40814, *42226, *42227 and *42235.</li> <li>The questionnaire will no longer open for procedure codes: *41820, *41830, *41872 and *41874. However, these codes continue to require prior authorization.</li> <li>For BCN Advantage: The questionnaire will no longer open. The codes listed in the column to the left will continue to require prior authorization.</li> </ul>

#### Questionnaires being removed

On Feb. 23, the following questionnaires were removed from the e-referral system.

Questionnaire	Affected lines of business	Procedure codes
Endoscopy, upper gastrointestinal, for Gastroesophageal Reflux Disease (GERD)	<ul><li>BCN commercial</li><li>BCN Advantage</li></ul>	The following procedure codes no longer require prior authorization: *43191, *43192, *43193, *43195, *43196, *43197, *43198, *43200, *43202, *43214, *43231, *43233, *43235, *43237, *43238, *43239, *43241, *43242, *43248, *43249, *43250, *43253, *43259
Responsive neurostimulator/deep brain stimulation, trigger Responsive Neurostimulation for the	BCN commercial     BCN Advantage	The following procedure codes no longer require prior authorization: *61863, *61864, *61880, *61885, *61888
Treatment of Refractory Focal Epilepsy		
Sacral nerve neuromodulation / stimulation for fecal incontinence	<ul><li>Medicare Plus Blue</li><li>BCN Advantage</li></ul>	The following procedure codes will continue to require prior authorization: *64561, *64581,
Sacral nerve neuromodulation / stimulation for urinary incontinence	DCIV Advantage	*64590 <b>Note</b> : These questionnaires will continue to
Sacral nerve or gastric stimulation, trigger		open for BCN commercial.
Sacral nerve urinary or fecal incontinence, trigger		

#### 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 **Preview questionnaires and medical necessity criteria**.

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 "Preview questionnaires and medical necessity criteria for select services" heading.

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