COVID-19 utilization management changes
For Blue Cross’ PPO (commercial), Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members
Revised May 29, 2020

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In this document, we outline the utilization management changes we’ve put in place to make it easier for providers — both contracted and noncontracted — to deliver testing and treatment services related to coronavirus, or COVID-19, to Blue Cross Blue Shield of Michigan and Blue Care Network members.

The information in this document will be updated as needed and applies to members covered by these lines of business, unless otherwise noted:

- Blue Cross’ PPO (commercial)
- BCN HMO (commercial)
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- Medicare Plus Blue PPO
- BCN Advantage

Updated: More COVID-19-related utilization management changes

Initially published May 26, 2020, as a web-DENIS message
Republished May 29, 2020, as an updated web-DENIS message

We’ve updated this message, which was first published on May 26, 2020. The new date on which clinical review is again required for acute care admissions with non-COVID-19-related diagnoses is June 13, 2020. (We had previously announced the date was June 1, 2020.) Please use this message as the most current source of information on these changes.

Over the past few weeks, Blue Cross Blue Shield of Michigan and Blue Care Network implemented utilization management changes aimed at supporting our providers during the COVID-19 emergency.

We’re making additional utilization management changes at this time.

Here are the important things you need to know.

Temporary change ending: Waiving of clinical review requirements for acute care admissions with non-COVID-19 diagnoses

Starting June 13, 2020, clinical review is again required by Blue Cross / BCN Utilization Management for acute care admissions with non-COVID-19-related diagnoses. This means you’ll need to submit clinical documentation along with your authorization requests.

Note: For admissions with COVID-19-related diagnoses, see the section below titled “Changes extended temporarily, through June 30, 2020.”

Changes extended temporarily, through June 30, 2020

- For acute care admissions with COVID-19-related diagnoses, no clinical review is required. However, you must still continue to notify the plan (that is, you must submit an authorization request without clinical documentation).

- For CT scans of the chest to rule out pneumonia diagnosis associated with COVID-19, AIM Specialty Health does not require clinical review for procedure codes *71250, *71260 and *71270. You only need to notify AIM Specialty Health®.

- For the first three days of admission to a skilled nursing facility for members transferred from acute care, Blue Cross / BCN Utilization Management and naviHealth do not require clinical review. However, you must notify Blue Cross /
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BCN (by submitting the authorization request with no clinical documentation) or naviHealth (by contacting naviHealth prior to transferring the member).

Starting July 1, 2020, you must submit clinical documentation along with your authorization requests for the acute care admissions, CT scans and SNF admissions described in this section.

Change in the duration of authorization approvals for elective and non-urgent services
For elective and non-urgent services:

• All authorizations approved on or before May 25, 2020, will be valid through Dec. 31, 2020.

• All authorizations approved on or after May 26, 2020, will also be valid through Dec. 31, 2020. Exception: For authorizations approved with an end date that goes beyond Dec. 31, the end date identified in the authorization approval will be honored.

This applies to authorizations approved for in-state and out-of-state providers on or after the following dates:

• Blue Cross / BCN Utilization Management: March 13, 2020
• AIM Specialty Health: April 6, 2020
• eviCore healthcare: March 26, 2020

This doesn’t apply to Flexlink® groups for which a third-party administrator makes authorization determinations. Contact the third-party administrator on the back of the member's ID card for instructions.

Additional change: Turnaround time on post-acute care determinations
naviHealth will make a same-day determination on all Medicare Advantage post-acute care requests and, for certain admissions to SNFs, will implement an expedited review process. Due to increased workloads, naviHealth is no longer able to make a determination on these requests within two hours.

Both Blue Cross / BCN Utilization Management (for commercial members) and naviHealth (for Medicare Advantage members) will continue to assist providers in locating post-acute care providers, especially for difficult transitions.

More information
The information in this message has been added to the COVID-19 utilization management changes document, which you can access on our ereferrals.bcbsm.com
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website, on the Blue Cross Authorization Requirements & Criteria page and the BCN Authorization Requirements & Criteria page.

This information applies to the following members, unless otherwise noted:

- Blue Cross’ PPO (commercial)
- BCN HMOSM (commercial)
- Medicare Plus BlueSM PPO (Medicare Advantage)
- BCN AdvantageSM (Medicare Advantage)

Blue Cross has extended authorization dates on select medical and pharmacy benefit drugs for commercial members

Published April 16, 2020, as a web-DENIS message

To support our health care workers during the COVID-19 pandemic and ensure that members’ access to medications isn’t disrupted, Blue Cross Blue Shield of Michigan and Blue Care Network made changes to our prior authorization process.

For authorizations scheduled to expire between March 1 and June 1, 2020, we’ve extended the authorization end dates for select medical and pharmacy benefit drugs for Blue Cross’ PPO (commercial) and BCN HMOSM (commercial) members. August 1, 2020, is the new expiration date for these authorizations.

This change ensures continuity of care for members. It also helps ease the administrative burden on health care providers.

Exceptions: Short-course treatments are not eligible for authorization extensions. These include, but are not limited to, the following drugs:

- CAR-T therapies (Kymriah® and Yescarta®)
- Diclegis®
- Gene therapy (Luxturna® and Zolgensma®)
- Hepatitis C treatment drugs
- Xiaflex®
- Xifaxin®
In addition, Blue Cross’ PPO and BCN HMO members can refill their prescriptions early. We’re taking this extra precaution so members will have enough medication to stay healthy.

Blue Cross has extended authorization dates on select medical and pharmacy benefit drugs for Medicare Advantage members

Published April 16, 2020, as a web-DENIS message

To support our health care workers during the COVID-19 pandemic and ensure that members’ access to medications isn’t disrupted, Medicare Plus Blue PPO and BCN Advantage made changes to our prior authorization process.

- For medical benefit drugs: For authorizations that are scheduled to expire between April 1 and May 31, 2020, we’ve extended the authorization end dates for select medical drugs for Medicare Plus Blue and BCN Advantage members. August 31, 2020, is the new expiration date for these authorizations.

  Exceptions for medical benefit drugs: Certain treatments are not eligible for authorization extensions. These include, but are not limited to, the following drugs:

  - Remicade®
  - Xiaflex®
  - Non-preferred hyaluronic acid products such as Genvisc® 850 and Hyalgan®

- For pharmacy benefit drugs: All active prior authorizations for Medicare Plus Blue and BCN Advantage members that are scheduled to expire between April 1 and August 31, 2020, have been extended for 90 days. For example, if a member’s authorization was set to expire on May 1, it will be extended to July 30, and if an authorization was set to expire on July 1, it will be extended to Sept. 29.

In addition, Medicare Plus Blue and BCN Advantage members can refill their pharmacy prescriptions early. We’re taking this extra precaution so members will have enough medication to stay healthy.

These changes ensure continuity of care for members. They also help ease the administrative burden on health care providers.

Benefit period extended for PT, OT and ST during the COVID-19 pandemic

Published April 17, 2020, as a web-DENIS message
We’re extending the benefit period for completing physical, occupational and speech therapy (and physical medicine services by chiropractors). Here’s what this means:

- Members whose plans stipulate a benefit period now have 180, not 60, consecutive days within which they must complete therapies that have already been authorized.

- The 180-day count starts on the date of the first treatment.

We’re doing this so it will be easier for these members to start or resume their therapies once COVID-19 shelter-in-place restrictions are lifted.

This is different from — and in addition to — the extension of the length of time authorizations are valid, which we communicated in an April 8, 2020, web-DENIS message. In that message, we said that therapy authorizations are now valid for 180 days. This 180-day count starts on the date the authorization is approved. This applies to all Blue Cross and BCN members for whom therapy requires authorization.

Here are the details about the benefit period change.

**Reason for extending the benefit period**

Some plans require that members complete their PT, OT and ST (and physical medicine services by chiropractors) within a benefit period of 60 consecutive days. The 60-day period typically starts with the date of the first treatment.

However, many members who are required to shelter in place may not currently be able to participate in therapy within the required time period.

**Extension of benefit period**

Members whose plans currently impose a 60-consecutive-day benefit period now have 180 consecutive days within which they must complete their therapies. Here are examples:

- **According to the 60-day benefit period**, a member with a 60-calendar-day benefit period may receive therapy from April 18, 2020, through June 17, 2020. The benefit is exhausted after June 17, 2020.


**What action to take**

For members whose therapies do not require authorization, no action is required. Those members will automatically be allowed 180 days to complete their therapies, starting from the first treatment date.

For members whose therapies require authorization by eviCore healthcare, here’s what to do:
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- For therapies authorized before March 26, you must request an extension of the 60-day benefit period specifically because of COVID-19. eviCore will extend the benefit period to 180 days, with the 180-day count starting on the date of the first treatment.

- For therapies authorized on or after March 26, the benefit period will automatically be set to 180 days, with the 180-day count starting on the date of the first treatment.

Additional information
This change:

- Applies to in-state and out-of-state providers for all Blue Cross' PPO, BCN HMO, Medicare Plus Blue PPO and BCN Advantage members whose plans have a 60-consecutive-day benefit period for therapies

- Doesn’t affect quantity limits, which still apply

- Is temporary, for the duration of the COVID-19 emergency, and is subject to revision upon further notice

- Is in addition to the extension of the length of time authorizations are valid, which we announced in the April 8 web-DENIS message

All therapies must be medically necessary and must be authorized, if the member’s plan requires authorization.

Changes to authorization durations for elective and non-urgent procedures, including PT, OT and ST, during the COVID-19 pandemic

This change is updated effective May 26, 2020. See the information titled "Updated: More COVID-19-related utilization management changes" earlier in this document.

First published April 8, 2020, as a web-DENIS message
Updated web-DENIS message published April 20, 2020

Due to the COVID-19 pandemic, the federal government has mandated that providers postpone all elective and non-urgent procedures.

As a result and to reduce your administrative burden, we’re making the following changes to authorization requests for elective procedures, including physical, occupational and speech therapy.

- For requests that have already been approved: The approvals will be valid for 180 days from the date on which the authorization was approved.
This change applies to authorization requests that were approved on or after the following dates:

- Blue Cross or BCN Utilization Management: March 13, 2020
- AIM Specialty Health®: April 6, 2020
- eviCore healthcare®: March 26, 2020
- For requests that are received through May 31, 2020: If approved, authorizations will be valid for 180 days.

These changes are in effect through May 31, 2020, and apply to in-state and out-of-state providers, for all lines of business, including Blue Cross' PPO, BCN HMO, Medicare Plus Blue PPO and BCN Advantage.

**Exception:** These changes don't apply to Flexlink® groups for which a third-party administrator makes authorization determinations. Contact the third-party administrator on the back of the member's ID card for instructions.

**Clinical review requirements are suspended through May 31 for all admissions to acute care hospitals and for transfers to skilled nursing facilities**

This change ends starting June 13, 2020, for admissions with non-COVID-19 diagnoses. For admissions with COVID-19 diagnoses, the change is extended through June 30, 2020. See the information titled "Updated: More COVID-19-related utilization management changes" earlier in this document.

Published April 2, 2020, as a web-DENIS message
Additional web-DENIS messages published April 3 and April 21, 2020

**What’s changed**

**Effective April 3 through May 31, 2020:**

- **Michigan acute care hospitals:** Clinical review requirements at all acute care hospitals for all diagnoses are suspended. This applies to all medical admissions.
- **Michigan post-acute care facilities:** Clinical review requirements for the first three days of all skilled nursing facility admissions are suspended for members who are transferring from an acute care hospital.

**Exception:** These changes do not apply to Flexlink® groups for which a third-party administrator makes authorization determinations. Facilities should check the back of the member’s ID card to determine whether a third-party administrator needs to be contacted prior to an admission.
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How to submit these requests
• For acute care admissions, no clinical review is required.

  There is an important notification step to take. Eligible facilities must notify the plan about each admission so that an authorization is in our system when we receive the claim.

  IMPORTANT! The authorization request you submit serves as the plan notification. You are not required to submit clinical documentation with the authorization request.

  We strongly encourage facilities to use our e-referral system to submit these requests. When facilities use e-referral, they won’t wait on hold on the phone.

  We’re updating the e-referral system to automatically approve these requests without clinical review. While we’re updating the system, some requests may pend, in error. In those cases, our staff will provide approval to the facility within 2 hours of submission, during normal business hours.

  Note: We reserve the right to audit these admissions at a later date.

• For post-acute care admissions:

  • There is an important notification step to take. For SNF admissions, we’re suspending clinical review requirements for the first three days when patients are transferred from an acute care hospital. However, facilities must notify the plan (for commercial members) or naviHealth (for Medicare Advantage members) about each admission so that an authorization is in our system when we receive the claim.

  IMPORTANT! The authorization request you submit serves as the plan notification. Facilities are not required to submit clinical documentation until the continued stay review, starting on the fourth day of the stay.

  • Inpatient rehabilitation and long-term acute care admissions still require clinical review. Blue Cross has adjusted our clinical review process to expedite these requests. A determination will be made within 2 hours, during normal business hours.

How to submit, based on the line of business:

• Continue to submit Blue Cross’ PPO and BCN HMO post-acute care authorization requests to the plan through the e-referral system or by fax. A decision will be provided within 2 hours, during normal business hours.

• Continue to submit Medicare Plus Blue and BCN Advantage post-acute SNF admission requests to naviHealth. A decision will be provided within 2 hours, during normal business hours.
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Note: Notify naviHealth by submitting an authorization request before the patient is transferred. You can do this through:

- CarePort Care Management (formerly known as Allscripts®)
- nH Access™, the naviHealth provider portal
- Calling 1-855-851-0843
- Faxing to 1-844-899-3730

Don’t send clinical documentation with your authorization request but do include the following information:

- Submit the following information to naviHealth with your notification:
  - Name and contact information for person notifying the plan
  - Patient demographics (name, date of birth, enrollee ID, etc.)
  - Name of ordering physician
  - Patient diagnosis
  - Name of accepting SNF

  Note: If you need assistance locating a SNF, include a request for assistance when you submit notification to naviHealth. They’ll have their clinicians reach out to local facilities.

We’re asking SNFs to confirm that naviHealth has received the required notification for each member before they accept the transfer. Once naviHealth receives the notification, they’ll provide a three-day authorization to transfer the patient to the SNF.

Failure to notify naviHealth means there’s no authorization in our system when we receive the claim from the SNF.

For elective services and referrals, keep existing approvals active and on file

If providers or facilities cancel elective services and plan to reschedule for the future, there is no need to contact Blue Cross or BCN to cancel or void authorizations or referrals. In addition:

- You can contact us at a later date to update the dates of service once the services are rescheduled.
- If you’ve already gone through the clinical review process, we recommend keeping the authorization active and on file to prevent unnecessary delays in the future.
AIM Specialty Health implemented an updated guideline for advanced imaging

This change is extended through June 30, 2020. See the information titled “Updated: More COVID-19-related utilization management changes” earlier in this document.

Effective March 13, 2020, AIM implemented an updated guideline for advanced imaging for services involving COVID-19 diagnoses.

You can access the guideline by logging in to the AIM provider portal and accepting the HIPAA disclaimer.

Note: As part of these changes, AIM is not requiring clinical review for CT scans of the chest when used to assess for COVID-19. You must continue to submit notification to AIM for this service so that an authorization is in our system when we pay the claim.

This applies to the following procedure codes:

- *71250
- *71260
- *71270

Laboratory network restrictions are lifted

For COVID-19 testing only, Blue Cross’ PPO, Medicare Plus Blue, BCN HMO and BCN Advantage will pay for testing from any laboratory provider in Michigan regardless of network status.

Read about this and other COVID-19-related information on laboratory testing in the document COVID-19 patient testing recommendations.

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