TheRecord




April 2018

Professional

# PGIP allocation amount to increase for most codes

Effective July 1, 2018, the amount of professional fees allocated to the Physician Group Incentive Program will increase from 5 percent to 7 percent.

Our innovative physician incentive program rewards performance and best practices, and is designed to improve the quality of patient care and reduce costs. The increase in the PGIP allocation will be used to fund new PGIP organized systems of care initiatives. There have been no increases in the PGIP allocation since 2013.

Your claims payment vouchers will reflect this change. Instead of reflecting a 5 percent allocation to PGIP, vouchers will now show a PGIP allocation amount of 7 percent of the allowed amount, which is based on the applicable fee schedule. Providers contractually agree in their participation agreements to allocate a portion of their reimbursement to PGIP.

"Aligning with changes to the PGIP allocation, the Blue Cross PPO conversion factors will be adjusted upward by approximately 2 percent," said Dr. Thomas Simmer, senior vice president and chief medical officer for Blue Cross Blue Shield of Michigan. For details, see the article, also in this issue, titled Blue Cross changing practitioner fees July 1.

Using the same approach that has created the largest Patient-Centered Medical Home program in the country, Blue Cross Blue Shield of Michigan is focused on helping OSCs build infrastructure and integrated care processes so these systems can offer more coordinated care to the population of patients they serve. From the outset, PGIP's long-term goal has been to encourage primary care doctors, specialists, hospitals and other providers to create high-functioning, comprehensive OSCs, and to support them in their efforts.

An increasing proportion of reimbursement is tied to the development of highly effective systems of care and rewarding provider performance for effectively managing their patient population. All funds from the PGIP incentive pool are distributed to physician organizations and OSCs that participate in PGIP to support physician practice and system transformation. No money is retained by Blue Cross for administrative costs.

For more information about PGIP, go to bcbsm.com/provider/value_partnerships/pgip. **Note:** Claims for Federal Employee Program® members are excluded from the PGIP allocation.

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# Blue Cross changing practitioner fees July 1

Blue Cross Blue Shield of Michigan will change practitioner fees, effective with dates of service on or after July 1, 2018. This change applies to services provided to our Traditional, TRUST and Blue Preferred Plus□, regardless of customer group. For most procedures, adjustments will reflect an average 2 percent increase in the conversion factors.

Blue Cross will use the 2018 Medicare resource-based relative value scale for most relative value unit-priced procedures for dates of service on and after July 1. Most fees are currently priced using the 2017 values. At the same time, the conversion factor used to calculate anesthesia base units for anesthesia procedures will remain $58.65 throughout Michigan.

Each year, Blue Cross adjusts its fee schedule to support an increase in value-based reimbursement. This is a continuation of the approach we've taken in the past as we

transition from a strictly fee-for-service payment model to one where reimbursement reflects the overall value of services delivered to the patient.

Fee schedules effective July 1 will be available on web-DENIS on April 1. To find fee schedule information, go to the home page of web-DENIS and follow these steps:

1. Click on *BCBSM Provider Publications and Resources*.
2. Click on *Entire Fee Schedules and Fee Changes*. (After clicking on it, you'll be asked to accept the *End User Agreement*.)

Only claims submitted with dates of service on or after July 1 will be reimbursed at the new rates.

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# New opportunities for CQI value-based reimbursement: Find out how to become eligible

Blue Cross Blue Shield of Michigan's Value Partnerships program is pleased to announce expanded opportunities for practitioners who participate in select Blue Cross Collaborative Quality Initiatives. We've expanded the number of eligible CQIs to 13 for the 2019 reimbursement period, which begins March 1, 2019. This list includes the five CQIs added for the 2018 reimbursement period, which began March 1, 2018, and one CQI added for the 2017 reimbursement period.

Earning CQI VBR means that eligible practitioners can receive reimbursement for participation in a CQI, in accordance with the Value-Based Reimbursement Fee Schedule. The VBR Fee Schedule sets fees at greater than 100 percent of the Standard Fee Schedule.

Measures and a population-based scoring method have been developed by CQI coordinating centers, in collaboration with consortium clinical leadership and Blue Cross. Each CQI uses a unique scoring method that best fits the nature of the collaborative.

Population-based performance is measured and scored using one of these approaches:

- Affiliated hospital or site — Physician performance is grouped by the collective average of the physicians at their primary hospital or site. Affiliation is determined by the coordinating center and consortium members.
- Affiliated physician organization — Physician performance is grouped by the collective average at the PO.

- Collaborative-wide — Physician performance is based on the collective average of all physicians.
- Regional — Physician performance is assessed at a regional level.
- Physician practice — Physician performance is based on the collective average at the physician practice.

**Reimbursement period of March 1, 2018 to Feb. 28, 2019**

Practitioners will be eligible to receive CQI VBR from March 1, 2018, through Feb. 28, 2019, if they're enrolled in the Physician Group Incentive Program and participate in these CQIs:

- Anesthesiology Surgery Performance Improvement & Reporting Exchange Collaborative, also known as ASPIRE
- Blue Cross Blue Shield of Michigan Cardiovascular Consortium, also known as BMC2
- Michigan Anticoagulation Quality Improvement Initiative, also known as MAQI2
- Michigan Surgical Quality Collaborative, also known as MSQC
- Michigan Oncology Quality Consortium, also known as MOQC
- Michigan Urological Surgery Improvement Collaborative, also known as MUSIC

**Reimbursement period of March 1, 2019 to Feb. 29, 2020**

In addition to the above CQIs, practitioners will be eligible to receive CQI VBR from March 1, 2019, through Feb. 29, 2020, if they're enrolled in the Physician Group Incentive Program and participate in these CQIs:

- Michigan Arthroplasty Registry Collaborative Quality Initiative, also known as MARCQI
- Michigan Bariatric Surgery Collaborative, also known as MBSC
- Michigan Emergency Department Improvement Collaborative, also known as MEDIC
- Michigan Radiation Oncology Quality Collaborative, also known as MROQC
- Michigan Surgical Quality Collaborative, also known as MSQC
- Michigan Spine Surgery Improvement Collaborative, also known as MSSIC
- Michigan Society of Thoracic and Cardiovascular Surgery Collaborative, also known as MSTCVS

Physicians who meet the CQI performance expectations will receive 103 percent of the Standard Fee Schedule for CQI VBR **in addition** to any specialist VBR opportunity available through PGIP.

**Eligibility guidelines**

As a reminder, for a physician to be eligible for CQI VBR, he or she must meet the performance targets set by the coordinating center, and these guidelines:

- The physician must be enrolled in Blue Cross' PGIP program through an affiliated PGIP physician organization for at least one year.
- The physician must have contributed data to the CQI's clinical data registry for at least two years, including at least one year's worth of baseline data, to be considered eligible.

A physician organization nomination isn't required for CQI VBR. Instead, the CQI coordinating center notifies Blue Cross about which physicians meet the appropriate performance targets. The PO will notify physicians who receive CQI VBR, as it does for other specialist VBR.

Physicians are limited to receiving 103 percent of the Standard Fee Schedule for CQI performance, even if they participate in more than one CQI. For example, if a physician participates in both the BMC2 and MSQC CQIs and the physician's performance is such that he or she would be eligible for CQI VBR for both, the physician will receive 103 percent VBR.

**Contact information for managers of CQI coordinating centers**

Contact the appropriate CQI coordinating center manager listed in the table below for more information about these CQIs.

| CQI | Name | Email | Website |
|---|---|---|---|
| ASPIRE | Tory (Victoria) Lacca | lacca@umich.edu | aspirecqi.org |
| BMC2 | Andrea Jensen, MA, MS | jensenag@umich.edu | bmc2.org |
| MAQI2 | Brian Haymart RN, MS | khaymart@umich.edu | maqi2.org |
| MARCQI | Rochelle Igrisan | igrisanr@umich.edu | marcqi.org |
| MBSC | Amanda Stricklen, BSN | aoreilly@umich.edu | michiganbsc.org |
| | Rachel Ross, BSN | rachacoo@umich.edu | |
| MEDIC | Jessica Kauffmann | kauffmje@umich.edu | medicqi.org |
| MROQC | Melissa Mietzel, MS, CCRP | hillmel@umich.edu | mroqc.org |
| MSQC | Beth Seese | elizasan@umich.edu | msqc.org |
| MSSIC | Lisa Pietrantoni, BS, CCRC | lpietra1@hfhs.org | mssic.org |
| MSTCVS | Patty Theurer, BSN | ptheurer@umich.edu | mstcvs.org |
| MTQIP | Judy Mikhail, RN, MBA, PhD | jmikhail@umich.edu | mtqip.org |

| | | | |
|---|---|---|---|
| MUSIC | Susan Linsell, MHSA | slinsell@umich.edu | musicurology.com |
| MOQC | Louise Bedard, MSN, MBA | pbed@umich.edu | moqc.org |

Click here to access a printable PDF with detailed information about the measures and scoring for the March 1, 2019, to Feb. 29, 2020, reimbursement period.

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# Value-based reimbursement and PCMH designation effective dates are changing

Primary care physician value-based reimbursement and Patient-Centered Medical Home designation effective dates are changing to assure that all data is complete before producing and releasing the final results. The new dates are Sept. 1, 2018, through Aug. 31, 2019. This schedule will apply in future years.

The current value-based reimbursement level and PCMH designation status, which was slated to end on June 30, 2018, is extended through Aug. 31, 2018.

Primary care physicians who meet certain criteria are eligible for reimbursement in accordance with the value-based reimbursement fee schedule, which sets fees at greater than 100 percent of the standard fee schedules. To receive this reimbursement, physicians must meet the criteria associated with PCMH designation, clinical quality value-based reimbursement, provider-delivered care management, cost benchmark or advanced practice.

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# Updates to Medicare Plus Blue$^{SM}$ PPO outpatient claim editing process coming in May

Starting in May 2018, Blue Cross Blue Shield of Michigan will update its Medicare Plus Blue PPO outpatient claim editing processes. We're doing this to:

- Promote correct coding.
- Integrate local and national coverage determination guidelines in a way that will simplify our claims payment system.

These improvements will make our claims payment system easier for you and your billing staff to navigate. Unique clinical editing reason codes will appear on the 835 response files or provider vouchers.

As a Medicare Advantage organization, our Medicare Plus Blue PPO medical and payment policies comply with:

- National coverage determinations
- General coverage guidelines within original Medicare manuals and instructions
- Written coverage decisions of the local Medicare administrative contractor

**Reminder:** When billing Medicare Plus Blue PPO claims, you should follow:

- Centers for Medicare & Medicaid Services medical policies
- American Medical Association Current Procedural Terminology coding guidelines
- National bundling edits, including the National Correct Coding Initiative

As part of your contract with us, health care providers affiliated with the Medicare Plus Blue PPO network agree to supply services to Blue Cross members and bill according to the above guidelines and requirements.

If you have questions about the Medicare Advantage PPO claim editing process, contact Provider Inquiry at 1-866-309-1719.

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# New programs and preauthorization changes to PPO radiology management program take effect July 1, 2018

Beginning on July 1, 2018, the PPO radiology management program, administered by AIM Specialty Health, will be adding a cardiology and in-lab sleep study program for Medicare Advantage PPO members and a cardiology program for PPO members.

The additional cardiac procedures for both commercial and Medicare Plus Blue$^{SM}$ members will include:

- Percutaneous coronary intervention
- Peripheral vascular ultrasound
- Diagnostic coronary catheterization

Additionally, Blue Cross Blue Shield of Michigan will require prior authorization for **in-lab sleep testing** by instate providers for Medicare Plus Blue. Preapproval must be obtained for the following procedure codes:

- *95805
- *95807
- *95808
- *95810
- *95811

The in-lab sleep study program is similar to what we have in place for non-MA commercial PPO.

All authorized attended sleep study services should be performed at a laboratory or center accredited by the American Academy of Sleep Medicine or the Joint Commission.

All TRUST providers performing sleep study services for our PPO members must be certified in sleep medicine by a board recognized by Blue Cross.

The procedure codes will require preauthorization for both office settings and hospital outpatient locations. A list of these codes will be available at aimspecialtyhealth.com** in June 2018. You can also refer to Blue Cross' online provider manuals.

You can get authorization through AIM's provider portal at aimspecialtyhealth.com** or by contacting AIM at 1-800-728-8008.

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# Ciox Health now retrieving our medical records for Medicare Advantage risk adjustment services

Blue Cross Blue Shield of Michigan and Blue Care Network request medical records every year to comply with:

- The Centers for Medicare & Medicaid Services' standards for data submission and coding accuracy
- CMS and the U.S. Department of Health and Human Services regulations and quality standards for patient care

Here are the vendors who perform medical record retrievals on our behalf:

1. **Ciox Health:**
    - This vendor continues to retrieve in-state Medicare Advantage members' medical records for risk adjustment services.
    - Ciox Health is contractually bound to preserve the confidentiality of members' protected health information obtained from medical records. This is in accordance with the Health Insurance Portability and Accountability Act of 1996.
2. **Inovalon:**
    - This vendor continues to retrieve our in-state Healthcare Effectiveness Data and Information Set, or HEDIS®, medical records. This vendor performs retrievals of Blue Cross PPO and Medicare Advantage PPO members' records from March through May each year.
    - This is also the vendor for our out-of-state Medicare Advantage risk adjustment chart retrieval services.
3. **Verscend:** This vendor continues to retrieve medical records for our in-state commercial (non-Medicare) risk adjustment business.

**Reminder:** You won't need to submit patient-authorized information releases to comply with medical records requests when both the provider and health care plan have a relationship with the patient, and the information relates to this relationship [45 CFR 164.506(c)(4)]. For more information about privacy rules, go to hhs.gov/ocr/privacy.**

Behavioral health providers only need to submit documentation that confirms the diagnosis the patient is being treated for, such as encounter notes, SOAP notes or progress notes. This documentation doesn't require a signed consent from the patient. Psychotherapy notes containing personal information between the provider and patient **are not being requested**.

If you have any questions, contact Blue Cross provider outreach consultants Sue Brinich at 586-839-8614, Tom Rybarczyk at 313-378-8259 or Corinne Vignali at 313-969-0417.

Ciox Health, Inovalon and Verscend are independent companies that do not provide Blue Cross products or services.

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# Blue Cross and BCN's newborn coverage policy changes

Blue Cross Blue Shield of Michigan and Blue Care Network's newborn coverage policy has changed, retroactive to Jan. 1, 2017, for insured business.

Here's how the new policy works:

Subscribers are still required to add newborns within the time frames allowed in their contracts to obtain coverage for new dependents. However, Blue Cross and BCN have changed our newborn coverage policy so that even if a newborn is **not** added to the subscriber's contract within the required time frames, we'll cover both facility and professional inpatient claims for the newborn during the first 48 hours for a vaginal delivery and the first 96 hours for a cesarean delivery, as an extension of the mother's maternity benefit.

This coverage only applies if the mother has Blue Cross or BCN coverage on the newborn's date of birth as a subscriber, spouse or dependent.

Blue Cross and BCN won't pay a newborn claim if it's determined that the newborn had other coverage on the date of birth or if the subscriber contacts customer service to indicate they don't want us to pay the claim.

You'll want to encourage subscribers to add newborns within the time frames allowed under their contracts to obtain coverage for their newborns beyond the 48 or 96 hours.

This change is being applied retroactively to Jan. 1, 2017. As a result, some newborn claims have been reprocessed to pay for facility and professional inpatient services within the 48-hour and 96-hour thresholds where the mother had our coverage on the newborn's date of birth and the newborn didn't have other coverage.

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# Provider forums starting in May

Blue Cross Blue Shield of Michigan and Blue Care Network's 2018 provider forums begin in May. This year, the morning sessions will have content specifically geared to physician office staff who are responsible for closing gaps related to quality measures and coding.

A special morning session on understanding the patient experience and how to improve it

within practices will be targeted to office managers and staff. Topics will include:

- The patient experience — why it's important to your practice and how you can improve it.
- HEDIS®** measures.
- 2018 CPT updates and coding scenarios for primary care physicians and specialists.

Afternoon sessions will be geared toward all office personnel and will cover topics such as:

- New provider service model
- Authorizations
- e-referral
- The opioid epidemic
- Behavioral health
- Updates for Provider Enrollment and Data Management and for the Provider Automated Response System

Here's the schedule of events:

- Registration begins at 7:30 a.m.
- The morning session starts at 8 a.m., includes a continental breakfast and ends at 11:30 a.m.
- The afternoon session begins at noon, includes lunch and ends at 4 p.m.

You can register for the full day or choose to attend just the morning or afternoon session.

These forums provide valuable information to keep your staff up to date on the latest developments. We look forward to seeing you soon.

| Location | Date | Registration |
|---|---|---|
| **Novi**<br>Four Points Sheraton<br>27000 S. Karevich Drive<br>Novi, MI 48377 | Tuesday, May 8, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Pontiac/Auburn Hills**<br>Crowne Plaza<br>1500 N. Opdyke Road | Thursday, May 10, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session |

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|---|---|---|
| Auburn Hills, MI 48326 | | ONLY |
| | | Click here for P.M. session ONLY |
| **Grand Rapids**<br>DoubleTree Grand Rapids Airport<br>4747 28th St. SE<br>Grand Rapids, MI 49512 | Tuesday, May 15, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Kalamazoo**<br>The Fetzer Center<br>Western Michigan University<br>2251 Business Court Kalamazoo, MI 49008 | Wednesday, May 16, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Ann Arbor**<br>Courtyard Ann Arbor<br>3205 Boardwalk<br>Ann Arbor, MI 48108 | Tuesday, May 22, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Sterling Heights**<br>Wyndham Garden<br>34911 Van Dyke<br>Sterling Heights, MI 48312 | Thursday, May 24, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Port Huron**<br>DoubleTree by Hilton<br>800 Harker St.<br>Port Huron, MI 48060 | Tuesday, June 5, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Okemos/Lansing**<br>Lansing Community College | Thursday, June 7, 2018 | Click here for BOTH sessions |

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|---|---|---|
| 5078 Cornerstone Drive<br>Lansing, MI 48917 | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Traverse City**<br>West Bay Beach<br>615 E. Front St.<br>Traverse City, MI 49686 | Tuesday, June 12, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Marquette**<br>Holiday Inn Marquette<br>1951 US-41<br>Marquette, MI 49855 | Tuesday, June 19, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |
| **Frankenmuth**<br>Bavarian Inn Lodge<br>1 Covered Bridge Lane<br>Frankenmuth, MI 48734 | Wednesday, June 27, 2018 | Click here for BOTH sessions |
| | | Click here for A.M. session ONLY |
| | | Click here for P.M. session ONLY |

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# Reminder: Update your *Provider Authorization* form when changes occur

Blue Cross Blue Shield of Michigan is dedicated to safeguarding the protected health information of our members. These safeguards include completion of the *Trading Partner Agreement* and *Provider Authorization* forms (as part of the electronic data interchange setup process). All EDI trading partners must complete these forms before they can exchange PHI with Blue Cross.

Terms of the *Trading Partner Agreement* require you to notify Blue Cross of any changes

in your trading partner information. You must update your *Provider Authorization* form if you change:

- Service bureaus or clearinghouses
- Software vendors
- Billing services
- The recipient for your 835 files

Updating the form ensures that information routes to the proper destination.

You don't need to update the *Provider Authorization* form if your submitter and Trading Partner IDs don't change.

**When to review your information**
You should review your Provider Authorization information if you:

- Join a new group practice
- Left a group practice and now bill using your own NPI
- Hire a new billing service
- Start submitting claims through a clearinghouse or change clearinghouses
- Decide you no longer want to receive 835 remittance files
- Select a new destination for your 835s

You must update your Provider Authorization information if you'll send claims using a different submitter ID or route your 835s to a different unique receiver or Trading Partner ID.

To make changes to your EDI setup:

- Log in at bcbsm.com/providers.
- Click *Quick Links*.
- Click *Electronic Connectivity (EDI)*, then click on *How to use EDI to exchange information with us electronically*.
- Click *Update your Provider Authorization Form* under *EDI Agreements*.

If you have questions about EDI enrollment, contact our Help Desk at 1-800-542-0945. For assistance with *TPA* and *Provider Authorization* forms, select the TPA option.

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# What you need to know about Blue Cross

**How to access our online provider manuals**

Everything you need to know to do business with Blue Cross is included in our online provider manuals. From the home page of web-DENIS, click on *Provider Manuals* to access them.

There's certain information our participating providers need to know about doing business with Blue Cross Blue Shield of Michigan. This article provides a summary of key information.

**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** | • Regular and routine care – within 30 business days<br>• Urgent care – within 48 hours<br>• After-hours care – 24 hours, seven days a week |
| **Access to behavioral health care** | • Not life-threatening emergency – within six hours<br>• Urgent care – within 48 hours<br>• Initial visit for routine care – within10 business days<br>• Follow-up routine care – within 30 business days of request |
| **Access to specialty care** | High-volume specialist including, but not limited to:<br><br>**OB-GYN**<br><br>• Regular and routine care – within 30 business days<br>• Urgent care – within 48 hours<br><br>High-impact specialist:<br><br>**Oncologist**<br><br>• Regular and routine care – within 30 business days<br>• Urgent care – within 48 hours |

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

**Affirmative statement about incentives**
Medical 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.

**Clinical practice guidelines**
For medical and behavioral health care, Blue Cross follows Michigan Quality Improvement Consortium guidelines, which can be found on the **mqic.org**** website.

**Comprehensive care management**
To learn about Blue Cross comprehensive care management, use your online provider manual. To find the information on **bcbsm.com**:

- Click on the *For Members* tab.
- Click on *Health and Wellness*
- Scroll down to *Case Management* or *Chronic Condition Management* and click on *Learn More*.

**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:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters & Resources*.
- Click on *Clinical Criteria & Resources.*

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

**Note:** Criteria for Federal Employee Program® utilization management decision-making can be found at **fepblue.org**.

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

- Click on *Quick Links*.
- Click on *Preauthorization and precertification.*
- *Click on* then *Medical policy, precertification and preauthorization router.* Use the button to select *Medical Policy,* then follow online prompts.

FEP policies can be found at **fepblue.org**.

**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 the *Important Information* page on our website and click on *Learn More* under "Rights and responsibilities" for more information.

**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 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 brand-name and generic drug, as well as applicable copay, depending on the member's plan. See the *Pharmacy Services* page on our website for more details.

We recommend that you visit this page at least quarterly to access our drug lists and view updates. Go to **bcbsm.com/providers**. 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 the Customer Service number on the back of their member ID card. TTY users should call 711.

**Utilization management staff availability**
Department telephone numbers and hours are shown in the Preapproval Decisions/Utilization Management Decisions section of the "Appeals and problem resolution chapter" of the provider manuals.

**Behavioral health care — New Directions**
New Directions Behavioral Health is an independent company administering behavioral health benefits on behalf of Blue Cross. For information on the New Directions Behavioral Health Quality Improvement Program, click here.**

Contact information:

- Commercial PPO and Traditional programs: 1-800-762-2382
- Federal Employee Program: 1-800-342-5849

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| **Behavioral health** | New Directions medical necessity criteria for behavioral health |

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|---|---|
| **criteria** | admissions are reviewed annually and updated as needed. Providers may download it at **ndbh.com**** or request a printed copy by contacting New Directions at 1-800-528-5763. Providers may also view or print this document by accessing via web-DENIS. |
| **Behavioral health member rights and responsibilities** | For members' behavioral health services rights and responsibilities, click here.** |
| **Behavioral health statement about incentives** | Decisions about utilization of behavioral health services are made only on the basis of eligibility, coverage and appropriateness of care and services. New Directions doesn't specifically reward, hire, promote or terminate practitioners or other individuals for issuing denials of coverage. Utilization decision-makers don't receive incentives that would result in under-utilization. |

**For more information**

- Information about our programs and additional resources are available on the *Important Information* page of our website.
- To request a printed copy of any of the information contained in this article, call Quality and Population Health at 248-455-2808.
- If you have any questions about the information in this article, contact your provider consultant.

**Blue Cross Blue Shield of Michigan doesn't own or control this website.

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# Select insulins with comparable alternatives won't be covered, effective June 1, 2018

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans won't be covering all formulations of the following insulin products for all drug lists, effective June 1, 2018:

- Apidra®, Apidra® Solostar®
- Humalog® (except Junior Kwikpen®), Humalog® Mix
- Humulin® (except U-500), Humulin® Kwikpen®

- Insulin products of the same type are interchangeable and work the same way to lower A1c. The following table includes covered comparable alternatives available at a lower cost to the member:

| Insulin products **not** covered beginning June 1, 2018 | Cost to Blue Cross (PPO) member | Cost to Blue Care Network (HMO) member |
|---|---|---|
| Apidra®, Apidra® Solostar | Full cost (not covered) | Full cost (not covered) |
| Humalog® (except Junior Kwikpen®), Humalog® Mix | | |
| Humulin® (except U-500), Humulin® Mix | | |
| **Covered alternatives** | **Cost to Blue Cross (PPO) member** | **Cost to Blue Care Network (HMO) member** |
| Novolin® (all forms) | Preferred brand copayment | Generic copayment |
| Novolog®, Novolog® Mix | | |

This was already effective Jan. 1, 2018, for the Custom Select Drug List.

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select drugs and stop covering them when there are more cost-effective or over-the-counter alternatives available for our commercial members.

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# We'll cover Shingrix® shingles vaccine, beginning April 1, 2018

Blue Cross Blue Shield of Michigan and Blue Care Network's Commercial Pharmacy will cover Shingrix at zero cost share, beginning April 1, 2018, for members ages 50 and older.

Shingrix prevents shingles and complications from the disease.

Shingrix was approved in October 2017 for the prevention of herpes zoster in healthy adults ages 50 and older. It's the preferred shingles vaccine by the Centers for Disease Control and Prevention.

Blue Cross and BCN Pharmacy will also continue to cover the Zostavax® shingles vaccine at zero cost share for members ages 60 and older.

The CDC recommends that healthy adults ages 50 and older get Shingrix even if they:

- Had shingles
- Received Zostavax
- Aren't sure if they had chickenpox

Patients who received Zostavax should wait at least two months after it's administered before they can receive Shingrix.

Shingrix is administered as two injections. The second injection should be given at least 60 days and up to six months after the first injection.

Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible.

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# Certain topical lidocaine products won't be covered, effective May 1, 2018

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans are making some changes to the drugs we cover.

**We'll no longer cover certain topical lidocaine products, effective May 1, 2018. Affected members can continue to fill prescriptions through April 30, 2018, but they'll be responsible for the full cost after this date.**

The following table includes the products that aren't covered, effective May 1, and over-the-counter alternatives that are available for members without a prescription:

| Prescription drug not covered beginning May 1, 2018 |
| --- |
| Lidocaine jelly 2% |
| Lidocaine ointment 5% |
| **Over-the-counter alternatives** |
| Lidocaine gel 2%, 4% |

| |
|---|
| Lidocaine ointment 2%, 4%, 5% |

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select drugs and stop covering them when more cost-effective or over-the-counter alternatives are available for our commercial members.

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# Blue Cross to begin contracting with out-of-state home infusion therapy providers

Effective April 1, 2018, Blue Cross Blue Shield of Michigan will begin contracting with out-of-state home infusion therapy, or HIT, providers. Blue Cross will no longer require out-of-state HIT providers to have a physical location in Michigan, as outlined in Addendum B of the provider participation agreement.

Out-of-state HIT providers will be required to follow **all other** contractual obligations of the provider participation agreement, including contracted fee schedules and billing requirements.

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# Use flight information form for non-emergency air ambulance authorization requests

As a reminder, effective for dates of service on or after April 2, 2018, all non-emergency air ambulance transports for Blue Cross Blue Shield of Michigan PPO commercial and Blue Care Network HMO℠ commercial members require authorization.

Requests to authorize non-emergency flights must be submitted to and approved by Alacura Medical Transportation Management LLC before the flight. This requirement applies to both in-state and out-of-state air ambulance transports.

Emergency flights — when the patient can't safely wait six hours for the flight to take off — don't require authorization. This includes situations that involve delays due to weather or stabilizing the patient. When it's an emergency, just transport the patient.

**How to request an authorization for non-emergency flights**

To contact Alacura about authorizing a non-emergency flight request, do the following:

- Complete the *Air ambulance flight information (non-emergency)* form and fax it, along with clinical documentation in support of the request, to Alacura at 1-844-608-3572.
- Call Alacura at 1-844-608-3676 to obtain an authorization number.

**Reason for authorization requirement**

**A**ir ambulance transports that aren't medically necessary or that are flown by noncontracted providers expose Blue Cross and BCN members to significantly greater out-of-pocket costs and are much costlier for the plan. The requirement for authorization prior to non-emergency flights is expected to lower costs for Blue Cross and BCN members and customers.

**Additional information**

Additional details about this change are available in the original articles published on this topic:

- In the March 2018 issue of *The Record*, in the article titled Starting April 2, 2018, non-emergency air ambulance services require authorization for commercial members.
- In the March-April 2018 issue of *BCN Provider News*, in the article titled Non-emergency air ambulance services require authorization starting April 2, 2018, for commercial members, on Page 41.

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# Medicare Advantage Diagnosis Closure Incentive program continues in 2018

Blue Cross Blue Shield of Michigan and Blue Care Network are continuing the Medicare Advantage Diagnosis Closure Incentive program this year for dates of service on or after Jan. 1, 2018.

The program applies to Medicare Advantage patients, including those covered by:

- Blue Cross Medicare Plus Blue℠ PPO
- Medicare Plus Blue℠ Group PPO
- BCN Advantage℠ HMO-POS
- BCN Advantage℠ HMO

The program rewards participating primary care doctors for having annual, face-to-face visits with Blue Cross and BCN Medicare Advantage patients to evaluate, document and code diagnoses according to standards set by the Centers for Medicare & Medicaid Services.

Doctors will receive a financial incentive for closing diagnosis gaps identified by Blue Cross and BCN. A gap is a suspected or previous condition that hasn't been documented and coded in the current year.

***Diagnosis Evaluation Panel***

The *Diagnosis Evaluation Panel* on Medicare Advantage Health e-Blue℠ or BCN Health e-Blue℠ — found in the Provider Secured Services area of **bcbsm.com** — lists patients who are suspected of having a condition, based on one of the following, but whose diagnoses haven't been submitted to Blue Cross or BCN in the current year:

- Pharmacy claims
- Medical claims
- Other supplemental data sources
- Prior-year diagnoses

An identified gap can be closed after a face-to-face visit with the patient in 2018. During this visit, the doctor should manage, evaluate, assess or treat the condition and document the diagnosis in the patient's medical record following CMS guidelines. Then close the gap through one of the following methods:

- Confirm the diagnosis code:
    - By submitting a claim with the diagnosis code
    - Through Health e-Blue
    - By submitting the patient's medical record
- Check Health e-Blue to confirm that the patient doesn't have the suspected condition.

You shouldn't close a gap because you're not actively treating the condition. Only close a diagnosis gap if you've:

- Conducted an office visit
- Addressed the condition
- Determined that the patient no longer has the condition or the suspected condition doesn't exist

Information on Health e-Blue is refreshed monthly so doctors can track their progress in closing identified diagnosis gaps.

**Rewards for closing gaps**

Blue Cross and BCN will pay doctors $100 for each Medicare Advantage member with one or more gaps identified between Jan. 1 and Sept. 30, 2018, and for whom all gaps are closed during a face-to-face visit by Dec. 31, 2018.

More information about this incentive program will be posted on Health e-Blue for Medicare Advantage primary care doctors in the first-quarter 2018.

If you don't have access to Health e-Blue, you can request it on the application for Provider Secured Services and complete the section for Health e-Blue. For more information, go to *How do I get access to Provider Secured Services?*

If you already have access to Provider Secured Services and Health e-Blue and just need to update users, fill out this authorization form and fax it to the number on the form.

**web-DENIS member care alerts**

When checking patient eligibility and benefits on web-DENIS, check your member care alerts. The alerts have been updated to include 2018 patient gaps in care.

These alerts are color-coded to help you identify patients' needs quickly, and they display a printable list of diagnosis gaps and treatment opportunities for patients.

**2017 incentive payment**

If you participated in the 2017 Diagnosis Closure Incentive program, your incentive payment will be mailed to you by the end of the third quarter in 2018.

**Training available**

We can provide training to doctors and their office staff about proper documentation, coding guidelines and the importance of closing gaps for Medicare Advantage patients. The training is available only to Michigan providers at this time.

Follow these steps to access online training resources:

1. Log in to web-DENIS.
2. Click *BCBSM Provider Publications and Resources*.
3. Click *Newsletters & Resources*.
4. Click *Patient Care Reporting*, and in the *Training Resources* section select any of these training links:
    - *Online training for risk adjustment, documentation and coding*
    - eLearning module: *Online training: Best Practices for Medical Record Documentation*
    - *Documentation and ICD-10 coding tips for professional offices*

The 30-minute, eLearning module includes a 10-question assessment. If you score 80 percent or better, you'll receive one continuing education credit from the American Academy of Professional Coders.

These presentations are also available in *BCN Provider Publications and Resources* under the *Other Resources* menu. Click on *Patient Care Reporting for Risk Adjustment*.

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# Reminder: Medicare patients at risk for Type 2 diabetes eligible for new diabetes prevention program starting April 1

As we recently informed you, your Medicare patients who have Part B coverage and are at risk for Type 2 diabetes are eligible to participate in the new Medicare Diabetes Prevention Program starting April 1. It's offered at no cost to Blue Cross Blue Shield of Michigan members.

In a random controlled trial, the program was proven by the National Institutes of Health to greatly reduce the progression of prediabetes to Type 2 diabetes. Program services are delivered in community settings by lifestyle coaches. The coaches are trained by organizations that are recognized by the Centers for Disease Control and Prevention. To learn more about the program, click here.**

Medicare criteria for eligibility are:

- Enrollment in Medicare Part B
- Blood value (one of the following):
  - Fasting plasma glucose of 100-125 mg/dL
  - A1c value between 5.7 and 6.4
  - Oral glucose tolerance test between 140 mg/dL and 199 mg/dL
- Body mass index greater than 25 (If Asian, greater than 23)
- No diagnosis of end-stage renal disease, Type 1 or Type 2 diabetes; previous gestational diabetes is not an exclusion to participation.

**For details on how eligible members can enroll in the program, call the program administrator, Solera Health, at 1-866-653-3837 or visit bcbsm.com/prevent-diabetes.**

**Note:** Patients with Medicare supplemental plans shouldn't enroll through Solera. Diabetes Prevention Program providers should follow their normal CMS billing procedures for members with Medicare supplemental plans.

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# Details available on 2018 FEP skilled nursing facility benefit

The chart below describes the Federal Employee Program® skilled nursing facility benefit coverage for both the Basic and Standard options.

| FEP benefit coverage | SNF benefit |
|---|---|
| Basic Option | There's no benefit for inpatient SNF care. |
| Standard Option with primary Medicare Part A | Limited to coverage of the first through 30th day for each benefit period as defined by Medicare. Medicare covers days 1-20 in full.<br><br>For days 21-30, Medicare covers the stay except for the copayment, which FEP covers.<br><br>There's no FEP benefits beyond 30 days. (Members can't use a Flexible Benefit Option to cover an SNF stay.)<br><br>FEP considers medical necessity met when Medicare Part A has made a payment for the stay. |
| Standard Option without primary Medicare Part A**<br><br>**Member doesn't have Medicare Part A or has secondary Medicare Part A. | FEP covers SNF admission for a maximum of 30 days annually. The benefit is also available to overseas members.<br><br>Requires precertification for medical necessity for the SNF setting.<br><br>Before admission, the member must provide signed consent for case management services enrollment and participate in case management throughout his or her SNF stay. |

If you have benefit questions, contact the FEP Customer Service line at 1-800-482-3600.
If you have facility precertification questions, contact Precertification at 1-800-572-3413.
If you have questions about case management services, call 1-800-325-6278.

# Medical residents: Here's how you can join our network

Are you completing your medical residency training this summer?

If you are, remember to submit your Blue Cross Blue Shield of Michigan or Blue Care Network provider enrollment application **up to 60 days** before the date you complete your training.

It's important to apply within the required time frame, because if you apply **after** 60 days, your application will be denied and you'll have to reapply.

Before you can begin the credentialing process with Blue Cross and BCN, you must complete the CAQH ProView application.

Visit the CAQH ProView™** website for more information on application requirements.

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# We're changing the payment policy when evaluation and management services are billed with surgery

Evaluation and management, or E&M, services billed with modifier 25 will pay at 80 percent when billed with a surgery on the same day by the same provider, effective July 1, 2018. This reflects the modified effort to perform the service.

All Providers

# Reminder: Respond to our provider

# manuals survey and you could win a prize

If you haven't had a chance yet to complete our provider manuals survey, there's still time.

You could win a $25 gift certificate if you complete the online survey by April 30.

The survey takes only a few minutes and we value your insight. We use survey results to improve the manuals so they're easy to use and you can find the information you need quickly.

Participation in the survey isn't necessary to win. The drawing is open to all active Blue Cross Blue Shield of Michigan and Blue Care Network providers. Complete the survey no later than April 30, 2018, for a chance to win the prize. You can also enter to win by sending an email to ProviderOutreach@bcbsm.com by April 30. Write survey drawing in the subject line of the email and include your name and phone number.

All entries must be received by April 30, 2018. One winner will be selected in a random drawing from among all eligible entries. The winner will receive a $25 gift card. The drawing will take place by May 4, 2018. The winner will be notified by telephone or email following the drawing.

**Take advantage of our provider manuals**

Blue Cross and BCN have several provider manuals. Here's how to find them:

1. Go to bcbsm.com and log in to Provider Secured Services.
2. Click on *Provider Manuals* (lower right side of page).

You can also find the *Provider Manuals* tab within web-DENIS.

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# Use PARS or web-DENIS for eligibility and benefit information

We're requiring providers to use the Provider Automated Response System, or PARS, when calling to receive general benefit information. Our provider inquiry representatives will be available to help you if you're unfamiliar with using PARS or if the information you're looking for is not on PARS.

We would also like to remind you that you can use web-DENIS to obtain benefit and

eligibility information online.

Making sure that you use PARS and web-DENIS for benefit and eligibility information will help you save time since you don't have to wait in call queues.

For more information about PARS, check out the September *Record* article "*Here are some tips for navigating PARS*."

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# Battling the opioid epidemic

*We're continuing to bring you news and information to help you combat the opioid epidemic.*


**Next Drug Take Back Day scheduled for April 28**
The abuse of prescription drugs has fueled the country's opioid epidemic. That's why Blue Cross Blue Shield of Michigan and Blue Care Network continue to support National Prescription Drug Take Back Day events. At the most recent Drug Take Back Day in October, 912,305 pounds of potentially dangerous expired, unused and unwanted prescription drugs were turned in for disposal at more than 5,300 collection sites across the country. The next Drug Take Back Day is from 10 a.m. to 2 p.m. April 28, and we encourage you to let your patients know about it.

Visit the DEA Diversion Control Division website** and click on *Partnership Toolbox* to download posters, handouts and other materials to promote National Prescription Drug Take Back Day. Also, you can visit the site on or after April 1 to locate collection sites near you. Many of the sites can be used throughout the year to dispose of unwanted drugs. We'll also be posting blogs related to Drug Take Back Day on MI Blues Perspectives so be sure to check it out. You can subscribe to MI Blues Perspectives from the home page and have new blogs sent directly to your email.

**CDC offers training on opioid prescribing guideline**
The Centers for Disease Control and Prevention offers web-based training** to help health care providers gain a deeper understanding of the CDC's opioid prescribing guideline. The web-based training features self-paced learning, case-based content,

knowledge checks and resources. The CDC also offers a webinar series on applying the CDC guideline in a primary care practice setting. It's taught by experts from the CDC and the University of Washington. Free continuing education credits are available.

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# Billing chart: Blues highlight medical, benefit policy changes

You'll find the latest information about procedure codes and Blue Cross Blue Shield of Michigan billing guidelines in the following chart.

This billing chart is organized numerically by procedure code. Newly approved procedures will appear under the *New Payable Procedures* heading. Procedures for which we have changed a billing guideline or added a new payable group will appear under *Updates to Payable Procedures*. Procedures for which we are clarifying our guidelines will appear under *Policy Clarifications*. New procedures that are not covered will appear under *Experimental Procedures*.

You will also see that descriptions for the codes are no longer included. This is a result of recent negotiations with the AMA on use of the codes.

We will publish information about new BCBS groups or changes to group benefits under the *Group Benefit Changes* heading.

For more detailed descriptions of the BCBSM policies for these procedures, please check under the *Medical/Payment Policy* tab in Explainer on web-DENIS. To access this online information:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications & Resources*.
- Click on *Benefit Policy for a Code*.
- Click on *Topic*.
- Under *Topic Criteria*, click on the drop-down arrow next to *Choose Identifier Type* and then click on *HCPCS Code*.
- Enter the procedure code.
- Click on *Finish*.
- Click on *Search*.

| Code* | BCBSM changes to:<br>Basic Benefit and Medical Policy, Group |
|---|---|

**Variations Payment Policy, Guidelines**

**NEW PAYABLE PROCEDURES**

| | |
|---|---|
| **77061, 77062, 77063, G0279**** | **Basic benefit and medical policy** |
| | **Digital breast tomosynthesis** |
| ****** Covered by Medicare | Digital breast tomosynthesis (3-D mammography) may be considered established as a screening or diagnostic modality in the assessment and management of breast cancer for individuals meeting criteria, effective March 1, 2018.<br><br>Diagnostic procedure codes are subject to cost-sharing requirements.<br><br>**Inclusions:**<br>Digital breast tomosynthesis may be considered established for screening for any of the following:<br><br>• Digital breast tomosynthesis is used in combination with digital screening mammography in high risk individuals.<br>• A qualified health care provider (ordering provider or radiologist) determines that digital breast tomosynthesis should be the primary mammographic study.<br><br>Digital breast tomosynthesis may be considered established for screening or diagnostic purposes when:<br><br>• Digital mammography alone is inadequate or insufficient, in the judgment of the radiologist reviewer, to support clinical decision-making.<br><br>**Exclusions:**<br><br>• Those not meeting the above criteria. |
| **99495** | **Basic benefit and medical policy**<br><br>**Procedure code 99495 is payable.**<br><br>Procedure code 99495 has changed from non-payable to payable, effective Jan. 4, 2018. The provider must communicate directly, electronically or by telephone with the |

patient or caregiver within two days of discharge from an inpatient hospital, skilled nursing facility or community mental health center stay, outpatient observation or partial hospitalization. A face-to-face visit must occur within 14 calendar days of the patient's discharge.

**UPDATES TO PAYABLE PROCEDURES**

**94772, 94774, 94775, 94777, A4556, A4557, E0619**

**Basic benefit and medical policy**

**Home cardiorespiratory monitoring for pediatric patients**

**Non-covered:**

**E0618**

The safety and effectiveness of home cardiorespiratory monitoring have been established. It may be considered a useful monitoring tool for patients meeting selection criteria.

The inclusionary and exclusionary guidelines have been updated, effective Feb. 1, 2018. At this time, procedure code E0618 will no longer be covered unless Medicare is the primary insurer.

**Note:** The monitor with a recording feature will remain a benefit.

**Inclusions:**
Home cardiorespiratory monitoring when initiated in infants younger than 12 months of age (see policy guidelines below for more about age limits) in any of the following situations:

- Those who have experienced a brief resolved unexplained event (previously known as apparent life-threatening event) and aren't considered lower risk following clinical evaluation
- Those with tracheostomies or anatomic abnormalities that make them vulnerable to airway compromise
- Those with neurologic or metabolic disorders affecting respiratory control, including central apnea and apnea of prematurity
- Those with chronic lung disease (e.g., bronchopulmonary dysplasia; see policy guidelines below).

Home cardiorespiratory monitoring in children over 12 months of age in any of the following situations:

- Those with home noninvasive ventilator use

- Those home invasive ventilator use
- Those with chronic lung disease
- Those with cyanotic heart disease

**Exclusions:**

- Home cardiorespiratory monitoring in infants with any siblings with a history of sudden infant death syndrome, but without at least one of the indications listed above
- Home cardiorespiratory monitoring in all other conditions, including, but not limited to, the diagnosis of obstructive sleep apnea
- Apnea monitors without an event recorder

**Policy guidelines**

Home cardiorespiratory monitoring is intended, in part, to alert caregivers to the need for intervention at the time of an event in patients with apnea and isn't appropriate for diagnosis of sleep-disordered breathing (central or obstructive).

This policy doesn't address the use of an unattended (unsupervised) home sleep study for the diagnosis and management of obstructive sleep apnea. If obstructive sleep apnea is a consideration, refer to the medical policy titled "Sleep Disorders – Diagnosis and Medical Management."

This policy applies only to the use of U.S. Food and Drug Administration approved home monitoring systems. A variety of commercially available baby monitoring devices are marketed to parents for monitoring infants' sleep, breathing and behavior. Although some of the devices include pulse oximetry, they aren't sold as medical devices and are therefore not cleared for marketing by FDA.

2016 Clinical Practice Guidelines from the American Academy of Pediatrics (Tieder et al., 2016) defined brief resolved unexplained event (formerly apparent life-threatening event) as: *An event occurring in an infant younger than 1 year when the observer reports a sudden, brief and now resolved episode of ≥1 of the following:*

1. cyanosis or pallor
2. absent, decreased or irregular breathing

3. marked change in tone (hyper- or hypotonia)
4. altered level of responsiveness

The diagnosis of bronchopulmonary dysplasia is dependent on gestational age and is based on the 2001 consensus definition from the U.S. National Institute of Child Health and Human Development (Jobe et al., 2001).

As suggested in a policy statement from the American Academy of Pediatrics, the physician should establish a review of the problem, a plan of care and a specific plan for periodic review and termination. Clear documentation of the reasons for continuing monitoring is necessary should monitoring beyond 43 weeks of postmenstrual age be recommended. Home cardiorespiratory monitoring for apnea is generally not considered appropriate for pediatric patients older than 1 year of age. There may be a subset of young children who require cardiorespiratory monitoring beyond 1 year of age, such as certain patients with home noninvasive or invasive ventilator use or chronic lung disease.

Home monitors should be equipped with an event recorder.

**GROUP BENEFIT CHANGES**

**General Motors**

Effective April 1, 2018, General Motors will allow payment for mental health and substance abuse claims associated with emergency room visit or service codes.

These codes include *99281, *99282, *99283, *99284 and *99285. If the claim meets the medical emergency criteria, services will pay according to the appropriate emergency room benefit guidelines. This applies to outpatient services only.

Inpatient mental health and substance abuse claims for these groups will be handled by Beacon Health.

**Group numbers:** 83640, 83650, 83200

**Joyson Safety Systems Acquisition LLC**

Joyson Safety Systems Acquisition LLC, group number 71765, has joined Blue Cross Blue Shield of Michigan, effective March 26, 2018.

**Group number:** 71765
**Alpha prefix:** PPO (TQK)

**Platform:** NASCO

**Plans offered:**
PPO, medical/surgical
Prescription drugs
Dental
CDH-HSA

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Facility

# Updates to Medicare Plus Blue$^{SM}$ PPO outpatient claim editing process coming in May

Starting in May 2018, Blue Cross Blue Shield of Michigan will update its Medicare Plus Blue PPO outpatient claim editing processes. We're doing this to:

- Promote correct coding.
- Integrate local and national coverage determination guidelines in a way that will simplify our claims payment system.

These improvements will make our claims payment system easier for you and your billing staff to navigate. Unique clinical editing reason codes will appear on the 835 response files or provider vouchers.

As a Medicare Advantage organization, our Medicare Plus Blue PPO medical and payment policies comply with:

- National coverage determinations
- General coverage guidelines within original Medicare manuals and instructions
- Written coverage decisions of the local Medicare administrative contractor

**Reminder:** When billing Medicare Plus Blue PPO claims, you should follow:

- Centers for Medicare & Medicaid Services medical policies
- American Medical Association Current Procedural Terminology coding guidelines
- National bundling edits, including the National Correct Coding Initiative

As part of your contract with us, health care providers affiliated with the Medicare Plus Blue PPO network agree to supply services to Blue Cross members and bill according to the above guidelines and requirements.

If you have questions about the Medicare Advantage PPO claim editing process, contact Provider Inquiry at 1-866-309-1719.

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# New programs and preauthorization changes to PPO radiology management program take effect July 1, 2018

Beginning on July 1, 2018, the PPO radiology management program, administered by AIM Specialty Health, will be adding a cardiology and in-lab sleep study program for Medicare Advantage PPO members and a cardiology program for PPO members.

The additional cardiac procedures for both commercial and Medicare Plus Blue[SM] members will include:

- Percutaneous coronary intervention
- Peripheral vascular ultrasound
- Diagnostic coronary catheterization

Additionally, Blue Cross Blue Shield of Michigan will require prior authorization for **in-lab sleep testing** by instate providers for Medicare Plus Blue. Preapproval must be obtained for the following procedure codes:

- *95805
- *95807
- *95808
- *95810
- *95811

The in-lab sleep study program is similar to what we have in place for non-MA commercial PPO.

All authorized attended sleep study services should be performed at a laboratory or center accredited by the American Academy of Sleep Medicine or the Joint Commission.

All TRUST providers performing sleep study services for our PPO members must be certified in sleep medicine by a board recognized by Blue Cross.

The procedure codes will require preauthorization for both office settings and hospital outpatient locations. A list of these codes will be available at aimspecialtyhealth.com** in June 2018. You can also refer to Blue Cross' online provider manuals.

You can get authorization through AIM's provider portal at aimspecialtyhealth.com** or by contacting AIM at 1-800-728-8008.

** Blue Cross Blue Shield of Michigan doesn't own or control this website.

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# Blue Cross and BCN's newborn coverage policy changes

Blue Cross Blue Shield of Michigan and Blue Care Network's newborn coverage policy has changed, retroactive to Jan. 1, 2017, for insured business.

Here's how the new policy works:

Subscribers are still required to add newborns within the time frames allowed in their contracts to obtain coverage for new dependents. However, Blue Cross and BCN have changed our newborn coverage policy so that even if a newborn is **not** added to the subscriber's contract within the required time frames, we'll cover both facility and professional inpatient claims for the newborn during the first 48 hours for a vaginal delivery and the first 96 hours for a cesarean delivery, as an extension of the mother's maternity benefit.

This coverage only applies if the mother has Blue Cross or BCN coverage on the newborn's date of birth as a subscriber, spouse or dependent.

Blue Cross and BCN won't pay a newborn claim if it's determined that the newborn had other coverage on the date of birth or if the subscriber contacts customer service to indicate they don't want us to pay the claim.

You'll want to encourage subscribers to add newborns within the time frames allowed under their contracts to obtain coverage for their newborns beyond the 48 or 96 hours.

This change is being applied retroactively to Jan. 1, 2017. As a result, some newborn claims have been reprocessed to pay for facility and professional inpatient services within the 48-hour and 96-hour thresholds where the mother had our coverage on the newborn's date of birth and the newborn didn't have other coverage.

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# Reminder: Update your *Provider Authorization* form when changes occur

Blue Cross Blue Shield of Michigan is dedicated to safeguarding the protected health information of our members. These safeguards include completion of the *Trading Partner Agreement* and *Provider Authorization* forms (as part of the electronic data interchange setup process). All EDI trading partners must complete these forms before they can exchange PHI with Blue Cross.

Terms of the *Trading Partner Agreement* require you to notify Blue Cross of any changes in your trading partner information. You must update your *Provider Authorization* form if you change:

- Service bureaus or clearinghouses
- Software vendors
- Billing services
- The recipient for your 835 files

Updating the form ensures that information routes to the proper destination.

You don't need to update the *Provider Authorization* form if your submitter and Trading Partner IDs don't change.

**When to review your information**
You should review your Provider Authorization information if you:

- Join a new group practice
- Left a group practice and now bill using your own NPI
- Hire a new billing service
- Start submitting claims through a clearinghouse or change clearinghouses
- Decide you no longer want to receive 835 remittance files
- Select a new destination for your 835s

You must update your Provider Authorization information if you'll send claims using a different submitter ID or route your 835s to a different unique receiver or Trading Partner ID.

To make changes to your EDI setup:

- Log in at bcbsm.com/providers.
- Click *Quick Links*.
- Click *Electronic Connectivity (EDI)*, then click on *How to use EDI to exchange*

*information with us electronically*.
- Click *Update your Provider Authorization Form* under *EDI Agreements*.

If you have questions about EDI enrollment, contact our Help Desk at 1-800-542-0945. For assistance with *TPA* and *Provider Authorization* forms, select the TPA option.

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# UAW Retiree Medical Benefit Trust (URMBT) clinic outpatient facility fees will no longer be reimbursed

Bundled payments previously made for outpatient services will no longer include fees for clinic visits (revenue codes 0510 to 0519) for UAW Retiree Medical Benefit Trust members with Medicare primary coverage. This change is the result of an audit where we identified that these fees were paid in error based on the customer's benefits.

While we don't plan to recover previous payments for these codes, effective Jan. 1, 2018, these services will be denied as a non-covered benefit.

Claims affected by this change include group numbers 71400, 71434, 71435, 71472 and 71436.

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**Pharmacy**

# Select insulins with comparable alternatives won't be covered, effective June 1, 2018

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans won't be covering all formulations of the following insulin products for all drug lists, effective June 1, 2018:

- Apidra®, Apidra® Solostar®
- Humalog® (except Junior Kwikpen®), Humalog® Mix

- Humulin® (except U-500), Humulin® Kwikpen®
- Insulin products of the same type are interchangeable and work the same way to lower A1c. The following table includes covered comparable alternatives available at a lower cost to the member:

| Insulin products **not** covered beginning June 1, 2018 | Cost to Blue Cross (PPO) member | Cost to Blue Care Network (HMO) member |
|---|---|---|
| Apidra®, Apidra® Solostar | Full cost (not covered) | Full cost (not covered) |
| Humalog® (except Junior Kwikpen®), Humalog® Mix | | |
| Humulin® (except U-500), Humulin® Mix | | |
| **Covered alternatives** | **Cost to Blue Cross (PPO) member** | **Cost to Blue Care Network (HMO) member** |
| Novolin® (all forms) | Preferred brand copayment | Generic copayment |
| Novolog®, Novolog® Mix | | |

This was already effective Jan. 1, 2018, for the Custom Select Drug List.

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select drugs and stop covering them when there are more cost-effective or over-the-counter alternatives available for our commercial members.

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# We'll cover Shingrix® shingles vaccine, beginning April 1, 2018

Blue Cross Blue Shield of Michigan and Blue Care Network's Commercial Pharmacy will cover Shingrix at zero cost share, beginning April 1, 2018, for members ages 50 and older.

Shingrix prevents shingles and complications from the disease.

Shingrix was approved in October 2017 for the prevention of herpes zoster in healthy adults ages 50 and older. It's the preferred shingles vaccine by the Centers for Disease Control and Prevention.

Blue Cross and BCN Pharmacy will also continue to cover the Zostavax® shingles vaccine at zero cost share for members ages 60 and older.

The CDC recommends that healthy adults ages 50 and older get Shingrix even if they:

- Had shingles
- Received Zostavax
- Aren't sure if they had chickenpox

Patients who received Zostavax should wait at least two months after it's administered before they can receive Shingrix.

Shingrix is administered as two injections. The second injection should be given at least 60 days and up to six months after the first injection.

Most Blue Cross and BCN commercial (non-Medicare) members with prescription drug coverage are eligible.

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# Certain topical lidocaine products won't be covered, effective May 1, 2018

To address the high cost of drugs and provide the best value for our members, Blue Cross Blue Shield of Michigan and Blue Care Network commercial plans are making some changes to the drugs we cover.

**We'll no longer cover certain topical lidocaine products, effective May 1, 2018. Affected members can continue to fill prescriptions through April 30, 2018, but they'll be responsible for the full cost after this date.**

The following table includes the products that aren't covered, effective May 1, and over-the-counter alternatives that are available for members without a prescription:

| Prescription drug not covered beginning May 1, 2018 |
| --- |
| Lidocaine jelly 2% |
| Lidocaine ointment 5% |
| **Over-the-counter alternatives** |
| Lidocaine gel 2%, 4% |

| |
|---|
| Lidocaine ointment 2%, 4%, 5% |

As part of this ongoing initiative, Blue Cross and BCN will continue to identify select drugs and stop covering them when more cost-effective or over-the-counter alternatives are available for our commercial members.



Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.