Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Prior authorization requirements for Michigan and non-Michigan providers

For Blue Cross commercial and Medicare Plus Blue℠

Revised May 2025

In this document

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This document describes the types of procedures and services that require prior authorization for Blue Cross commercial and Medicare Plus Blue members and indicates which entity manages prior authorizations.

Definitions

Term	Description
Prior authorization	Blue Cross Blue Shield of Michigan requires prior authorization for certain procedures to ensure that members get the right care at the right time and in the right location. Health care providers must submit prior authorization requests before providing services. For some procedures or services, providers must submit clinical documentation explaining why the proposed procedure or service is medically necessary.
e-referral	The e-referral system is an electronic system providers can use to submit prior authorization requests.
Electronic Provider Access, or EPA	EPA is a platform that providers who are outside of Michigan and who **aren't** registered with Availity® Essentials can use to submit prior authorization requests. These providers access EPA through their local Blue plan portal.

Important: Michigan's prior authorization law* requires health care providers to submit prior authorization requests electronically for commercial members. Alternate submission methods are allowed in the case of temporary technological problems, such as power or internet outages; see the information about submitting prior authorization requests through alternate methods below.

Determining whether procedure codes require prior authorization for a member

The steps required to determine whether procedure codes require prior authorization for a specific member vary depending on whether you're a Michigan or non-Michigan provider.

For complete information, refer to the Determining prior authorization requirements for members job aid by going to ereferrals.bcbsm.com and clicking on the following tile in the left navigation:

Behavioral health

Blue Cross commercial products and Medicare Plus Blue℠

Prior authorization is required for Blue Cross commercial and Medicare Plus Blue members for the following services, unless otherwise noted:

- Outpatient autism services (applied behavior analysis)
- Outpatient transcranial magnetic stimulation — applies only to Blue Cross commercial members
- Inpatient admissions and partial hospital program
- Residential mental health treatment — applies only to Blue Cross commercial members
- Subacute detoxification, inpatient

Prior authorization is not required for:

- Outpatient services other than those listed above
- Medicare primary contracts
- Coordination of benefits contracts

Prior authorization is required for outpatient repetitive transcranial magnetic stimulation (rTMS). It may be a benefit for patients with major depressive disorder that meet strict selection criteria. Criteria are available in the Blue Cross medical policy on Transcranial magnetic stimulation on the Medical Policy Router Search page at **bcbsm.com**. Coverage is limited to select groups.

Providers should verify member eligibility prior to seeking prior authorization. Claims will not be paid unless authorization is obtained. However, authorization approval doesn't guarantee payment.

All inpatient partial and residential mental health and substance abuse facilities are required to notify Blue Cross Behavioral Health℠ for all admissions and discharges; most admissions will require a clinical review.

Autism spectrum disorder

There are different types of services to treat autism, such as applied behavior analysis (ABA) services, which require prior authorization before treatment for select groups. Speech therapy, physical therapy and occupational therapy do not require authorization. For services that require prior authorization, an accurate diagnosis is necessary.

For more information on how members in Michigan and in other states can obtain a comprehensive diagnostic autism evaluation prior to starting treatment, refer to the Blue Cross Behavioral Health: Frequently asked questions for providers document on the

Blue Cross Autism webpage at **ereferrals.bcbsm.com**. In the table of contents, click *Autism evaluation and treatment changes*.

Behavioral health prior authorizations (including prior authorization for autism services) are conducted by Blue Cross Behavioral Health.

Groups whose prior authorizations are not managed by Blue Cross Behavioral Health can be viewed on the *Mental Health and Substance Use Disorder Carve-Out List,* which can be accessed by visiting our provider portal (availity.com*) and completing these steps:

1. Click *Payer Spaces* on the menu bar.
2. Click the BCBSM and BCN logo.
3. Click *Secure Provider Resources (Blue Cross and BCN)* on the Resources tab.
4. Click *Behavioral Health* on the Member Care menu.

How to submit a prior authorization request to Blue Cross Behavioral Health

Prior authorization requests can be submitted to Blue Cross Behavioral Health electronically or by phone. To submit requests electronically, follow these steps:

1. Login to our provider portal (availity.com*).
2. Click *Payer Spaces* on the menu bar, then click the BCBSM and BCN logo.
3. On the Applications tab, scroll down and click the *Blue Cross Behavioral Health* tile.

To submit by phone or for more information on prior authorization request submissions, refer to the Blue Cross Behavioral Health: Frequently asked questions for providers document on the Blue Cross Behavioral Health webpage at **ereferrals.bcbsm.com**.

Human organ transplants

Blue Cross commercial products (non-Medicare)

Providers must contact Blue Cross' Human Organ Transplant department for prior authorization for the following transplants and combination transplants:

- Bone marrow
- Heart
- Heart-Lung
- Kidney (fully insured only)
- Kidney-Liver
- Liver
- Lobar Lung
- Lung
- Multivisceral
- Pancreas
- Pancreas-Kidney
- Partial Liver
- Small Bowel

Prior authorization is not required for:

- Cornea or skin transplants
- Pre-transplant evaluations
- Donor benefits
- If Blue Cross is the secondary payer

For more information on how to obtain a transplant procedure authorization, see the e-referral User Guide. The pertinent information is in "Section IV: Referrals and Authorizations," in the subsection titled "5. Submit an Outpatient Authorization."

Alternate methods for submitting prior authorization requests for human organ transplants

If you're experiencing temporary technological problems that prevent you from accessing the e-referral system, such as a power or internet outage, use the following method to submit prior

authorization requests.

Call the Blue Cross' Human Organ Transplant department at 1-800-242-3504 to obtain a prior authorization. This department is available from 8 a.m. to 5 p.m. EST, Monday through Friday.

Medicare Plus Blue

All Medicare Plus Blue members have coverage for transplant procedures that are covered by traditional Medicare. Inquiries about coverage for transplants should be directed to Provider Inquiry at 1-866-309-1719.

Although prior authorization of transplants for Medicare Plus Blue members is not required, a request for an organizational determination can be sent to Blue Cross. Please fax your request with substantiating clinical information to 1-877-348-2251.

Inpatient admissions

Blue Cross commercial products (non-Medicare)

Prior authorization is required for:

- Acute care inpatient hospital medical and surgical admissions including but not limited to:
  - Admission for transplants
  - Sick newborn admissions (NICU/PICU)
- Complicated admissions related to maternity care may require an authorization
- Admissions to skilled nursing facilities
- Admissions to acute inpatient rehabilitation facilities
- Admissions to long-term acute care facilities

Prior authorization **isn't** required:

- For outpatient services

  Note: Prior authorization may be required for certain services.
- For maternity admissions, including C-section

  Note: Complicated admissions related to maternity care may require an additional authorization.
- For observation or short stay admissions
- When Blue Cross is the secondary payer

Acute and post-acute care facilities — Michigan (and other facilities with access to Availity)

The Blue Cross e-referral system is available 24 hours per day, 7 days a week to receive requests for inpatient admissions or transplant procedure authorizations through our provider portal on Availity.com.

Authorization requests must be submitted on the appropriate Blue Cross assessment form along with complete clinical documentation to support the necessity of inpatient stay or need for transplantation. Incomplete requests may delay the processing of the authorization; however, Blue Cross will attempt to reach out to obtain the additional information if a clinical review cannot be completed.

If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our legislative and accreditation time frames.

For more information on prior authorization requirements and how to submit an authorization request, refer to the following resources on **ereferrals.bcbsm.com**:

- Submitting acute inpatient authorization requests: Frequently asked question for providers document
- Post-acute care requirements: Information for providers document
- Blue Cross Acute Inpatient Medical and Surgical Admissions webpage
- Blue Cross Post-Acute Care webpage

For information on how to submit an authorization request through our provider portal, refer to the Getting Started webpage on **ereferrals.bcbsm.com**.

If you're experiencing temporary technological problems that prevent you from accessing the e-referral system, such as a power or internet outage, prior authorization requests can be submitted via fax. Refer to the appropriate Blue Cross assessment form for instructions:

- Acute inpatient hospital assessment form
- SNF/acute IPR assessment form
- LTACH assessment form

Acute and Post-acute care facilities — Non-Michigan (without access to Availity)

(Acute Inpatient Hospital, Inpatient Rehab, Skilled Nursing, Long Term Acute Care Hospitals)

Blue Cross Prior Authorization Services are available 24 hours per day, 7 days a week to

receive requests via fax. Initial authorization requests and requests for additional days (if applicable) **must be submitted** on the appropriate Blue Cross assessment form and along with the clinical documentation to support the necessity of the inpatient stay. The completed Blue Cross assessment form and supporting clinical documentation must be provided together or the request will not be processed. Blue Cross may attempt to reach out to obtain additional information in certain situations if a clinical review cannot be completed.

If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our accreditation time frames.

Note: For Blue Cross and Blue Shield Federal Employee Program®, or FEP, member requests to skilled nursing facilities, additional requirements may be needed prior to requesting prior authorization. Please contact FEP benefits at 1-800-482-3600.

Note: Non-Michigan providers can look up requirements without an Availity account by logging into their home plan's website and selecting an ID card prefix from Michigan, which will take you to the Pre-Service Review for Out-of-Area and Local Members screen.

To submit acute and post-acute care facility prior authorization requests via fax, use these forms:

- Acute inpatient hospital assessment form
- SNF/acute IPR assessment form
- LTACH assessment form

The forms should be legible and completed in their entirety, or the request will not be processed.

Note: InterQual criteria are utilized to complete acute hospital, skilled nursing, inpatient rehabilitation and long–term acute care prior authorization and recertification requests.

Requests will be processed during regular business hours, 8 a.m. to 5 p.m. EST, Monday through Friday and during select holidays.

Any non-urgent requests received after 5 p.m. or on a weekend or holiday will be processed the following business day according to the time it was received.

If you have not received a response from Blue Cross within 72 hours, providers can obtain the status of prior authorization requests during regular business hours by following this process:

1. Call 1-800-249-5103, when prompted enter or say the following:
2. The reason for your call, “Precertification”
3. Your Blue Cross facility code or 10-digit NPI (National Provider Identifier)
4. The member’s ID/policy number

5. The member's date of birth
6. The first five letters of the member's first name
7. The type of service needed (such as "hospital inpatient")

The prompts will give the members eligibility information, instruct you on where to find the fax assessment form and then ask if you still need Precert. If you say "Yes," you will be transferred to a representative in the Commercial Precertification department.

For more information, visit bcbsm.com/providers.

Blue Cross commercial retroactive reviews (post-service)

Blue Cross commercial will accept requests for retroactive reviews for acute care and post-acute care for 2 years after the date of service.

Blue Cross commercial peer-to-peer reviews for inpatient medical necessity denials
For providers who would like to request a peer-to-peer review for a Blue Cross commercial member due to a medical necessity denial, refer to the document How to request a peer-to-peer review with a Blue Cross or BCN medical director.

Blue Cross commercial appeals for inpatient medical necessity denials

For prior authorization medical necessity denials, Blue Cross Blue Shield of Michigan appeal requests will be accepted up to 45 days after the initial denial decision was issued. Providers must submit appeal requests in writing and include all additional information to substantiate the need for the inpatient stay. Fax the request and the additional information to 1-877-261-4555.

Medicare Plus Blue

Acute care facilities — Michigan

The Blue Cross e-referral system is available 24 hours per day, 7 days a week to receive requests for inpatient hospital admissions. Requests must be submitted within 24 to 72 hours of the admission with complete clinical documentation to support the necessity of the inpatient stay. Processing may be delayed if the request doesn't include complete information; however, Blue Cross will attempt to reach out to obtain the additional information if a clinical review cannot be completed based on the information received.

If the additional information is not received in a timely manner, Blue Cross will process the request with the information available in accordance with our accreditation time frames.

For more information on prior authorization requirements and how to submit an authorization request, refer to the following:

- Submitting acute inpatient authorization requests: FAQ for providers document
- The Blue Cross Acute Inpatient Medical and Surgical Admissions webpage at **ereferrals.bcbsm.com**

Acute care facilities — Non-Michigan

Providers can submit prior authorization requests for Blue Cross Blue Shield of Michigan members through their local Blue plan's electronic portal via the Electronic Provider Access, or EPA, system. Blue Cross encourages providers to submit requests through the EPA system to get a faster response. Requests must be submitted with complete clinical documentation to support the necessity of inpatient admissions. Incomplete requests will not be processed until all information is received; these requests are at risk of being denied due to a lack of information.

Note: If your local plan doesn't have electronic access, you can complete the Acute inpatient hospital assessment form and fax the form and clinical documentation. The form must be legible and completed in its entirety to reduce the possibility of processing delays.

Post-acute care facilities: Michigan and Non-Michigan

For dates of service **on or after** Oct. 1, 2024, prior authorization requests are managed by Blue Cross Blue Shield of Michigan. See the Blue Cross Post-Acute Care webpage at **ereferrals.bcbsm.com** for additional information.

For more information, refer to the Post-acute care requirements information for providers document at **ereferrals.bcbsm.com**.

For retroactive authorization requests submitted on or after Oct. 1 for dates of service before Oct. 1, submit the request through the e-referral system. Be sure to enter the Centers for Medicare & Medicaid Services-determined PDPM code in the Case Communication field. We'll accept retroactive requests through Sept. 30, 2025. If you have questions, send them to UMMedicarePACCA@bcbsm.com.

Retroactive reviews

Medicare Plus Blue will process retroactive authorization requests up to one year post-discharge for a post-acute acute care stay.

Medicare Plus Blue peer-to-peer reviews for medical necessity denials

Effective Jan. 4, 2021: Blue Cross Blue Shield of Michigan will no longer accept peer-to-peer requests for Medicare Plus Blue members for inpatient medical hospital admission denials.

Facilities are encouraged to follow the two-level provider appeal process for Blue Cross to reevaluate the denial decision on an inpatient admission request. See the "Contracted MI Provider Acute Inpatient Admission Appeals" section in the *Medicare Plus Blue℠ PPO Manual*.

Contracted Michigan provider acute inpatient admission appeals

Medicare Plus Blue appeal requests will be accepted up to 45 days after the date of the denial decision. (The date on which the decision was made is included in the denial notification.) Requests must include additional clarifying clinical information to support the request.

Medicare Plus Blue will notify the provider of the appeal decision within 30 calendar days of receiving all necessary information.

Requests can be submitted by faxing 1-877-495-3755.

Medical benefit drugs

Blue Cross commercial products and Medicare Plus Blue

Some medications administered by healthcare professionals require prior authorization, and certain clinical criteria must be met before they can be administered. For more information:

- Click this link for the medical policy, criteria and request form: Medical Policies.
- Refer to the Blue Cross Medical Benefit Drugs page on the **ereferrals.bcbcm.com** website:
    - For information on Blue Cross commercial requirements, look in the “Blue Cross commercial” column.
    - For information on Medicare Plus Blue requirements, look in the “Medicare Plus Blue” column.

Other medical/surgical procedures

Medicare Plus Blue

To see a list of elective (non-emergency) procedures or services that require prior authorization, see the Blue Cross Authorization Requirements & Criteria page on our **ereferrals.bcbsm.com** website. Scroll to the “For Medicare Plus Blue members” section and see the subsection titled “Authorization criteria and preview questionnaires – Medicare Plus Blue.”

Prescription drugs

Blue Cross commercial products (non-Medicare)

Some drugs require prior authorization, and certain clinical criteria must be met before they can be dispensed. Other drugs are part of our step therapy program, which means the patient must have been treated with one or more formulary agents before these drugs are covered.

Drugs that require prior authorization or step therapy requirements differ based on the formulary the member's plan uses.

For drug coverage information, see the For Providers: Drug Lists page on **bcbsm.com/providers**. Select the Prior Authorization and Step Therapy Guidelines document for the member’s specific drug list.

For prior authorizations for pharmacy benefit drugs, the prescribing physician should complete a form online and submit it through an electronic prior authorization, or ePA, tool.

Alternate methods for submitting prior authorization requests

If you're experiencing temporary technological problems that prevent you from submitting an electronic prior authorization, such as a power or internet outage, use the following methods to submit prior authorization requests.

Providers can submit the completed electronic form to Blue Cross by fax 1-866-601-4425 or mail to:

Blue Cross Blue Shield of Michigan
Pharmacy Services

P.O. Box 312320
Detroit, MI 48231-2320

For more information on obtaining clinical criteria or submitting a prior authorization request, refer to the Blue Cross Pharmacy Benefit Drugs page on the **ereferrals.bcbsm.com** website.

Providers can obtain clinical criteria and forms by calling 1-800-437-3803.

Medicare Plus Blue and Prescription Blue℠ PDP

Medicare Plus Blue MAPD plans, and Prescription Blue PDP plans include prescription drug coverage. These plans generally cover drugs listed in our formulary as long as:

- The drug is medically necessary
- The prescription is filled at a network retail or mail-order pharmacy
- All other plan rules are followed, such as prior authorization, step therapy and quantity limit requirements

The formulary document, which is updated regularly, provides a brief description of the plans' benefits. Refer to page on **bcbsm.com/providers** and select the appropriate plan list for details.

Providers can request a coverage determination (prior authorization, step therapy, formulary exception or quantity limit exception) by phone at 1-800-437-3803 or by using the information in the Medicare Plus Blue PPO section of the *For Providers Drug Lists* page on **bcbsm.com/providers**.

Advanced imaging, cardiology and in-lab sleep study services

Blue Cross commercial products (non-Medicare)

Michigan providers: Prior authorization is required from Carelon Medical Benefits Management (formerly known as AIM Specialty Health®) for the procedure codes indicated on these lists:

- Procedures that require prior authorization by Carelon: Cardiology, radiation oncology, radiology (high technology) and sleep studies (in lab)
- Radiation Oncology Prior Authorization List for UAW Retiree Medical Benefits Trust non-Medicare members

Non-Michigan providers: Prior authorization is required for non-Michigan providers for certain groups.

To determine which Blue Cross commercial groups are not subject to Carelon prior authorization requirements, refer to the Carelon exclusion list for Blue Cross Blue Shield of Michigan Commercial document.

Medicare Plus Blue

Michigan providers: All contracted Medicare Plus Blue PPO physicians are required to contact Carelon Medical Benefits Management before ordering the following services for Medicare Plus Blue members, including UAW Retiree Medical Benefits Trust members with Medicare Plus Blue coverage:

- Select advanced imaging
- Outpatient cardiology
- Cardiac resynchronization therapy
- Implantable cardioverter defibrillator
- Arterial ultrasound services

Non-Michigan providers: Prior authorization is not required for non-Michigan providers except for UAW Retiree Medical Benefits Trust members residing in Alabama, Florida, Indiana, Missouri and Tennessee. Contact Blue Cross to obtain prior authorization requests for the services listed above for URMBT members.

All providers: Refer to the document Procedures that require authorization by Carelon to see which outpatient advanced imaging, cardiology and in-lab sleep study services require prior authorization. For additional information, refer to the Blue Cross Carelon-Managed Procedures page on ereferrals.bcbsm.com.

Air ambulance

Blue Cross commercial products (non-Medicare)

Only non-emergency flights require prior authorization. They must be authorized by Alacura Medical Transport Management. For instructions on how to submit a prior authorization request, refer to the Non-emergency air ambulance prior authorization program: Overview for Michigan and non-Michigan providers document on ereferrals.bcbsm.com. Do this prior to the flight.

Medicare Plus Blue

Emergency air ambulance services don't require prior authorization in or out-of-network only if furnished to a member whose medical condition is such that other means of transportation could endanger the person's health. Services must transport the member to the nearest appropriate facility that can provide care.

Non-emergency transportation requires documentation that other slower means of transportation could endanger the member's health. For questions, call Provider Inquiry at 1-866-309-1719.

Private duty nursing

Blue Cross commercial products (non-Medicare)

Private duty nursing services require prior authorization for dates of service on or after Oct. 1, 2022. Submit requests through the e-referral system.

For authorization requests and for billing, agencies should enter S9123 for an RN or S9124 for an LPN and indicate the total hours as units (1 unit = 1 hour).

For complete instructions on submitting a prior authorization request, see the Private duty nursing program document on ereferrals.bcbsm.com.

Home health care

Medicare Plus Blue

For dates of service on or after Oct. 1, 2024, prior authorization isn't required for home health care services.

Other services

EviCore by Evernorth®: Blue Cross commercial and Medicare Plus Blue

Prior authorizations may be required by EviCore for outpatient radiation therapy (oncology) services for some members who reside in Michigan and who receive services from Michigan providers.

To determine whether the member requires a prior authorization by EviCore , follow the appropriate steps in the Determine prior authorization requirements for members document.

Providers can submit prior authorization requests through the EviCore provider portal, by following these steps:

1. Log in to our provider portal (availity.com*).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *EviCore Provider Portal* tile in the Applications tab.

Providers can also go to eviCore.com/provider* to submit a prior authorization request.

Medicare Plus Blue
Providers can submit electronic prior authorization requests or call EviCore at 1-877-917-2583.

Alternate methods for submitting prior authorization requests to EviCore (for Blue Cross commercial members)

If you're experiencing temporary technological problems that prevent you from accessing EviCore, such as a power or internet outage, use the following method to submit prior authorization requests.

Call EviCore at 1-877-917-2583 to submit a prior authorization request.

For more information about procedures managed by EviCore, see the following webpages:

- Blue Cross Oncology Service
- EviCore's Blue Cross Blue Shield of Michigan Provider Resources*

TurningPoint: Blue Cross commercial and Medicare Plus Blue

TurningPoint Healthcare Solutions LLC manages inpatient and outpatient authorizations for musculoskeletal procedures as follows:

Service	For these groups and individual members

Orthopedic procedures
Spinal procedures
	• Blue Cross commercial
	  ○ Most fully insured groups — Excludes MESSA members
	  ○ Select self-funded groups* — Includes UAW Retiree Medical Benefits Trust non-Medicare members
	  ○ All members with individual coverage
	• Medicare Plus Blue℠ — All groups and all members with individual coverage

Pain management procedures	• Blue Cross commercial
	  ○ Most fully insured groups — Excludes MESSA members
	  ○ Select self-funded groups* — Includes UAW Retiree Medical Benefits Trust non-Medicare members
	  ○ All members with individual coverage
	• Medicare Plus Blue — Prior authorization isn't required for dates of service on or after May 1, 2025. For dates of service before May 1, 2025, prior authorization is required for all groups and all members with individual coverage

See the document titled Procedure codes for which providers must request prior authorization to determine which procedure codes require authorization from TurningPoint.

Providers can submit prior authorization requests through the TurningPoint provider portal, by following these steps:

1. Log in to our provider portal (availity.com*).
2. Click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo.
3. Click the *TurningPoint Provider Portal* tile in the Applications tab.

For approved authorization requests, provide the appropriate facility with the authorization number.

Alternate methods for submitting prior authorization requests to TurningPoint

If you're experiencing temporary technological problems that prevent you from accessing Turning Point, such as a power or internet outage, use the following method to submit prior authorization requests.

To submit prior authorization requests, providers can fax the appropriate authorization request form to TurningPoint or call, as follows:

- For Joint and spine procedures fax form to 313-879-5509.
- For pain management authorizations fax form to 1-313-483-7323.
- Call TurningPoint at 1-833-217-9670 or 1-313-908-6040.

TurningPoint staff are available by phone from 8 a.m. to 8 p.m. EST, Monday through Friday, excluding holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day).

For more information on how to submit a prior authorization request to TurningPoint, refer to "How do I submit authorization requests to TurningPoint" section of the "Musculoskeletal procedure authorizations: FAQ" document on ereferrals.bcbsm.com website.

Retroactive requests

Providers can submit retroactive requests to TurningPoint for up to 90 days after the procedure is performed.

Non-Michigan providers

There are multiple methods for non-Michigan providers to access the TurningPoint provider portal. See the "How do I submit authorization requests to TurningPoint?" section in the Musculoskeletal procedure authorizations FAQ for more information.

Continuous glucose monitor products

Blue Cross commercial products (non-Medicare)

Michigan providers: Northwood, Inc. manages prior authorizations and the supplier network for continuous glucose monitor products, or CGM products and is the preferred provider for fully insured groups and individual members who reside in Michigan.

For more information, refer to the document Durable medical equipment, prosthetics, orthotics and medical supplies management program: Frequently asked questions for providers at **ereferrals.bcbsm.com**.

Non-Michigan providers: For members with addresses outside of Michigan, non-Michigan providers must use a DME provider that participates as a Traditional provider with their local Blue Cross plan.

Michigan and non-Michigan providers: Commercial members who have pharmacy benefit coverage through Blue Cross can obtain CGM products through a participating network

pharmacy. Prior authorization could be required in certain circumstances. For more information, see the document titled Continuous glucose monitor products: FAQs for providers.

Medicare Plus Blue

Michigan and non-Michigan providers:

For dates of service on or after Oct. 1, 2024, Medicare Plus Blue members must obtain their CGM products through a participating network pharmacy. Prior authorization could be required in certain circumstances.

Exception: UAW Retiree Medical Benefits Trust members with Medicare Plus Blue plans should continue to obtain their CGM products through a DME supplier.

Durable medical equipment, prosthetics and orthotics, including diabetes supplies

Exception: For CGM products refer to the "Continuous glucose monitor products" section in this document.

Blue Cross commercial and Medicare Plus Blue

Michigan providers: Northwood, Inc. manages prior authorizations and the supplier network for DME/P&O and is the preferred provider for the following groups and members who reside in Michigan:

- BlueCross commercial – fully insured groups and individual members
- Medicare Plus Blue members

For more information, refer to the document Durable medical equipment, prosthetics, orthotics and medical supplies management program: Frequently asked questions for providers at **ereferrals.bcbsm.com**.

Non-Michigan providers: For members with addresses outside of Michigan, non-Michigan providers must use a DME provider that participates as a Traditional provider with their local Blue Cross plan.

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