JULY-AUGUST 2024

BCN Provider News

Be sure to use the correct provider taxonomy code to avoid payment delays

We use taxonomy codes to assist in the identification of a provider when they're using one NPI for several Blue Cross Blue Shield of Michigan provider IDs.

Blue Cross and Blue Care Network claims payment systems don't use every taxonomy code listed in the National Uniform Claim Committee, or NUCC, code set list. In the enrollment and credentialing process, if you submit a taxonomy code that we don't use, we'll change it to a higher-level taxonomy code. You must use the Blue Cross and BCN-assigned taxonomy code during the billing process to avoid possible payment delays. This applies to both Blue Cross and BCN commercial and Medicare Advantage plans.

Taxonomy codes designate your provider specialty. To find the provider taxonomy code you're required to use when submitting electronic claims to Blue Cross and BCN, refer to these documents located on **bcbsm.com**:

- **Taxonomy Code Mapping - Facility Providers**
- **Taxonomy Code Mapping - Professional Providers**

Here's are some examples:

- If you're submitting a claim for a family practice physician, you use taxonomy code 207Q00000X. This code is listed on the *Taxonomy Code Mapping - Professional Providers* document, so there is likely no change from what was submitted during the enrollment and credentialing process.
- If you're submitting a claim for a pediatric cardiologist, you will not find that specialty listed on the *Taxonomy Code Mapping - Professional Providers* document. As a result, you'll need to use the higher-level taxonomy code for pediatrics, 208000000X, even if that is not the code that was submitted during the enrollment and credentialing process.

Feedback | Subscribe

Inside this issue…

Network Operations

Daniel J. Loepp *Tricia A. Keith*

Tricia A. Keith to succeed Daniel J. Loepp as president and CEO of Blue Cross Blue Shield of Michigan

On May 15, 2024, Blue Cross Blue Shield of Michigan's Board of Directors appointed Tricia A. Keith to succeed Daniel J. Loepp as president and CEO following his retirement on January 1, 2025.

Mr. Loepp had many achievements during two decades of leadership at Blue Cross, including transforming the company from a large single-state health insurance plan to a diversified multi-company enterprise of national scale.

Ms. Keith, a Michigan native and lifelong resident, will become the company's first female chief executive. She has been with Blue Cross Blue Shield of Michigan since 2006, and currently serves as executive vice president, chief operating officer and president of Emerging Markets.

"She has the energy, experience, and innovative spirit our company needs as health care continues to change," Mr. Loepp said. "She is the right leader at the right time for Blue Cross Blue Shield of Michigan."

For more information, visit **MiBluesPerspectives.com**.

Here's how medical residents can join our network

Medical residents interested in joining our network can submit their Blue Cross Blue Shield of Michigan or Blue Care Network provider enrollment application up to 60 days before they complete their training.

It's important to apply within the required time frame. If medical residents apply more than 60 days before the completion of residency training, we'll deny the application and residents will have to reapply.

The **CAQH Provider Data Portal**, formally known as CAQH ProView, application must be completed to begin the credentialing process with Blue Cross and BCN. To keep CAQH information current, complete the re-attestation every 120 days and update the Authorize section. Visit the **CAQH Provider Data Portal** for more information on application requirements.

Editor
Michael Gingerella
bcnprovidernews@bcbsm.com

Provider Communications
Catherine Vera-Burgos, Manager
Elizabeth Donoghue Colvin
Tracy Petipren
Deb Stacy

Graphics Design
Colleen McIver

How to protect yourself against health care fraud

Health care fraud is a serious crime that increases health care costs for everyone and can also present patient safety issues. Our Corporate and Financial Investigations Unit has put together the following tips to help protect you against health care fraud:

- **Verify requests for patient information**
  Provider offices may receive fraudulent requests for patient information, provider NPI numbers and provider signatures by standard mail, email or fax. Always verify requests before sending a response.
- **Verify patient ID**
  Ask for a picture ID to ensure that the person presenting the Blue Cross or BCN subscriber card is the owner of that card.
- **Use proper billing codes**
  Consult CPT and International Classification of Diseases code book and other resources to verify that the codes being used are appropriate and accurate.
- **Check patient history**
  To help prevent prescription drug fraud, ask patients if they are seeing or have obtained prescriptions from other doctors. Check Michigan Automated Prescription System (MAPS) reports.
- **Safeguard prescription pads**
  Prescription pads should not be left accessible to patients. Prescription fraud schemes are often perpetrated by use of stolen prescription pads or compromised e-prescribing passwords.
- **Make patient agreements**
  Enter into controlled substance or narcotics contracts with patients to express the importance of limiting medications usage as well as evaluating potential for addictive behaviors.

Action item

If you're suspicious of a request for information that you receive, contact our toll-free Fraud Hotline at **844-STOP-FWA** (844-786-7392) or send an email to **StopFraud@bcbsm.com**.

If you suspect a request may be fraudulent, don't respond to it!

When we conduct mass requests for medical records or patient information, we often notify you through a provider newsletter article or a provider alert. If you're suspicious of a request that you receive, you can contact our Fraud Hotline at **1-844-STOP-FWA** (1-844-786-7392) or send an email to **StopFraud@bcbsm.com**. We may ask you to share the request so we can check its legitimacy.

For more useful information, check out the Victimized Provider Project section of the Centers for Medicare & Medicaid website. The **Victimized Provider Project** helps keep providers from being held liable for overpayment for claims paid that are the result of identity theft.

By working together, we can help eliminate fraud, an effort that will improve patient safety and reduce costs.

Network Operations

Tips to help administrators keep patients' information secure

Unauthorized access to patients' protected health information is a very serious threat to all health care providers. In addition to personal health details, patient PHI often contains other valuable information such as Social Security Number, date of birth and account billable details. For these reasons, office administrators must do everything they can to minimize the risks associated with unauthorized access.

To help safeguard patient PHI and comply with federal law, office administrators are encouraged to incorporate the following steps as best practices:

- **Account management**
  Support a centralized tool for user account creation, modification, and termination.
  - Define, review, and update access permissions to align with job roles and responsibilities.
  - Provide clear instructions for employees to report any issues or concerns.
  - Provide a clear policy outlining employee access rights and privileges, such as, executing suitable member inquires.
- **Access review frequency**
  Initiate access reviews when employees change roles or departments; revoke access promptly.
  - Schedule quarterly or bi-annual audits of access levels to ensure compliance.
  - Update employee access and roles to align with current job functions.
- **Termination procedures**
  Set up procedures for promptly revoking access upon employee termination.
  - Coordinate with the Human Resources department to ensure access termination aligns with employee departure dates.
  - Conduct post-termination access audits to verify access removal.

For more useful tips, refer to the **Keep Office Information Secure** document on **ereferrals.bcbsm.com**.

Network Operations

New mini modules available to help you navigate the Blue Cross behavioral health provider portal

The provider training team would like to introduce two new mini modules that will help with some common issues our behavioral health providers sometimes experience within the Blue Cross behavioral health provider portal:

- *Blue Cross Behavioral Health Provider Portal Error Issue – Signing in*
- *Blue Cross Behavioral Health Provider Portal Error Issue – Authorization not found*

These take less than four minutes to complete and give tips on how you can resolve issues within the portal. Whether you are receiving an error at sign-on or when attempting to search an authorization, these modules can resolve issues to get you the outcome you are looking for. You can find these mini modules on the provider training site by searching "behavioral health" or "mini" in the search box on the upper right corner of the page.

To access the training site, follow these steps:

1. Log in to the provider portal at **availity.com**.
2. Click on *Payer Spaces* on the menu bar and then click on the BCBSM and BCN logo.
3. Under *Applications*, click on the *Provider Training Site* tile.
4. Click on *Submit* on the *Select an Organization* page.
5. Existing users who used the same email address as their provider portal profile email will be directed to the training site. If you used a different email address, contact **ProviderTraining@bcbsm.com** to update your profile.

If you're a new training site user, complete the one-time registration by entering your role and creating a password. This allows you to access the training site outside of the provider portal if needed.

If you need assistance navigating the provider training site, email **ProviderTraining@bcbsm.com**.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

New on-demand training available: Check out our latest learning path

Provider Experience continues to offer training resources for health care providers and staff. Our on-demand courses are designed to help you work more efficiently with Blue Cross Blue Shield of Michigan and Blue Care Network. As part of our ongoing efforts, we recently added another learning path.

Our newest learning path contains courses for the behavioral health community. This is our latest in the approach for helping providers and staff determine the right courses to take. We'll keep updating the courses as new ones are created that cover behavioral health topics. This will ensure you have the latest information that's easy to find in one spot.

The behavioral health learning path will feature a brand-new course, *Behavioral Health Basics*. The course is designed to close knowledge gaps in several areas of behavioral health to give a well-rounded view of behavioral health at Blue Cross and BCN. It addresses potential provider challenges, reviews current resources, walks through scenarios, and challenges the learner's knowledge along the way. You can also find upcoming courses in the learning path such as a mini-module on the Behavioral Health portal.

Professional providers and facilities should encourage those in the behavioral health field to view the new path. Simply open the Course Catalog on the provider training website and click on *Learning paths*.

Network Operations

PCPs to select one PO with an affiliated MCG to support all Blue Cross and BCN business

Blue Cross Blue Shield of Michigan and Blue Care Network are asking primary care providers to align with one physician organization, and that PO's affiliated medical care group, to receive support for all Blue Cross and BCN lines of business in which the PCP chooses to participate. This includes Blue Cross and BCN commercial and Medicare Advantage plans (Medicare Plus Blue℠ and BCN Advantage℠).

This alignment needs to occur before January 1, 2026, but PCPs are encouraged to consider their options and make any necessary changes now. Working with a Blue Cross PO and its related BCN MCG will maximize efficiency for Blue Cross and BCN reporting, incentives and value-based contracting. We expect this change to reduce the administrative burden on PCPs and result in more time for patient care.

What PCPs need to do

Review the **list of POs and their corresponding MCGs**.

- **If the PCP is already part of a PO and MCG that align**, there is no action needed. If you have any questions, contact your PO.
- **If the PCP is not already part of a PO or MCG**, review the list of POs and their corresponding MCGs and reach out to them to inquire about participation requirements, including the benefits and services they offer.
- **If the PCP is with one PO for Blue Cross contracts and an MCG that doesn't align to that same PO for BCN contracts**, determine which entity you will align with going forward. Talk to both entities to ensure you make an informed choice.
- **If the PCP is in the Upper Peninsula**, there is no need to align with a BCN MCG, as there is currently not a corresponding MCG to the Upper Peninsula Health Group PO.

Notes:

- A PCP can participate in the Blue Cross networks without aligning to a PO. However, we encourage PCPs to join a PO to maximize value-based reimbursement, incentive opportunities, and opportunities for a value-based contract.
- In some cases, a PCP may be able to participate in the BCN and BCN Advantage networks without aligning to a PO/MCG entity, but participation is limited based on the needs of the network. We encourage PCPs to join a PO/MCG entity to benefit from incentives, value-based opportunities and administrative support.

For more information

Here's where you can learn more:

- Read the article, **"Blue Cross and BCN align PCP contracting entities"** in the May-June 2024 issue of *Hospital and Physician Update*
- Contact your Blue Cross PO or BCN MCG
- Reach out to PO or MCG contacts in the **list of POs and their corresponding MCGs**

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

- *Register now for our virtual Behavioral Health Summit*, **Page 11**
- *AllianceRx Walgreens Pharmacy will become Walgreens Specialty Pharmacy on August 1*, **Page 13**

New webpage provides Medicare Advantage prior authorization clinical review criteria in one convenient location

Blue Cross Blue Shield of Michigan and Blue Care Network Medicare Advantage plans (Medicare Plus Blue℠ PPO, BCN Advantage℠ HMO, BCN Advantage℠ HMO-POS) require prior authorization for certain benefits.

Blue Cross and BCN recently launched the **Medicare Advantage Prior Authorization** webpage on **bcbsm.com** where you can quickly find clinical review criteria associated with services that require prior authorization. This new webpage puts the information you need in one convenient location.

Reminder

Before rendering services, make sure you check benefits, eligibility and medical policy coverage guidelines, using the self-service tools on our provider portal at **availity.com**.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Select Medicare Advantage members will receive Cologuard® test kit in June

Blue Cross Blue Shield of Michigan and Blue Care Network are working with Exact Sciences, an existing, credentialed colorectal cancer screening provider, to distribute in-home Cologuard test kits in June. The kits will go to select Medicare Plus Blue℠ PPO and BCN Advantage℠ members. Health care providers with patients who receive an advance notice letter about the kit should encourage them to take advantage of this convenient, no-cost screening.

Members who have a gap in care for colorectal cancer screening will receive a Cologuard screening kit. Once completed, members will be encouraged to discuss test results with their primary care providers.

Test result notification

	All results	Positive result
Blue Cross MA member	• Letter directing member to Exact Sciences MyChart to review results • Text message and email, if member provides contact information, notifying results are ready • Members can contact Exact Sciences Patient Support Line 24/7	• Up to three phone call attempts to notify member of positive result • If unable to reach member by phone, we'll mail a certified letter with the positive result attached
Primary care provider	• Mailed • Faxed, if fax number is provided • Provider offices can also receive results by contacting Exact Sciences at **1-844-870-8870**, view on the Epic Care portal or by requesting results at **https://www.cologuardhcp.com/contact-us**	

Cologuard by Exact Sciences is an independent company that provides colorectal testing services to Blue Cross Blue Shield of Michigan and Blue Care Network members.

Talk to Medicare Advantage members about how to maintain independence and confidence

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

- Fall risks and how to avoid them
- Physical activity and realistic exercise expectations
- Preventing urine leakage, for members who deal with incontinence
- Feeling good about their overall health and managing pain so they can do routine activities, for members who are experiencing a decline in health

We're encouraging our Medicare Advantage members to share their concerns with you like they would with a close friend. We're suggesting they write down their concerns and read from the list or hand it to you so you can start the discussion.

We also encourage you to discuss these issues with patients even if the patient doesn't initiate the conversation. Many patients don't ask questions about these topics because they forget or don't know what to ask, they're embarrassed or they assume they have to "live with it."

When you bring up these topics, it opens the door to a conversation that may not otherwise happen. It also helps your patients to know these are common issues and what types of questions they should ask going forward.

We appreciate your efforts to make members as comfortable as possible when discussing sensitive issues.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *Change coming to nonclinical, transitional care program through Home & Community Care,* **Page 9**
- *Use JW and JZ modifiers when billing Part B medical benefit drug claims,* **Page 14**
- *Elrexfio and Talvey to require prior authorization for most members starting June 20,* **Page 15**
- *Step therapy requirement to be added for VPRIV and Elelyso for Medicare Advantage members starting June 1,* **Page 16**
- *Pemfexy and Pemrydi RTU to have additional step therapy requirements for most members,* **Page 26**
- *Step therapy requirement added for botulinum toxins for Medicare Advantage members starting Aug. 5,* **Page 27**
- *Changes coming to prior authorization process for post-acute care services for Medicare Advantage members,* **Page 33**

Change coming to nonclinical, transitional care program through Home & Community Care

Currently, the nonclinical, transitional care program through Home & Community Care (formerly known as naviHealth, Inc.) is available to Medicare Plus Blue℠ and BCN Advantage℠ members who are discharged to their homes or to certain post-acute care facilities in Michigan from acute inpatient facilities. This program aims to reduce avoidable inpatient readmissions.

On May 31, 2024, Home & Community Care will discontinue this 30-day program for members who are discharged to their homes. As a result, Home & Community Care navigation specialists won't contact members discharged after May 1. This will ensure all members engaged in the program complete it by May 31.

Starting June 1, 2024, the program will be available only to our Medicare Advantage members discharged to certain post-acute care facilities in Michigan. For more information about the program and to view the list of post-acute care facilities, see the document **Nonclinical, transitional care program for Medicare Advantage**.

We updated our communications, including the document linked above, to reflect this change.

Blue Cross Blue Shield of Michigan and Blue Care Network are working to develop a plan to ensure seamless care for members who are discharged to their homes and are at low risk for readmission.

Home & Community Care is an independent company that provides nonclinical, transitional care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

An ongoing series of quick tips designed to be read in 60 seconds or less and provide your practice with information about performance in key areas.

Kidney Health Evaluation for Patients with Diabetes (KED)

To help close the diabetes care HEDIS measure, follow these tips for a kidney health evaluation:

- For patients 18 to 85 years of age with diabetes, complete both an eGFR (blood) **and** uACR (urine) test.
- The uACR component can be satisfied by ordering a quantitative urine albumin test (*82043) **and** a urine creatinine test (*82570) less than four days apart **or** a urine albumin creatine ratio (uACR) lab test. There isn't a CPT code for uACR. This test is reported through LOINC codes.
- If your practice performs in-office testing, determine what kind of analyzer you use and the type of urine albumin test being performed. Some analyzers only measure semi-quantitative urine albumin, which are reported using different codes and will **not** close gaps.
- Chronic Kidney Disease is classified using both the eGFR and uACR to appropriately assign a stage. CKD can be diagnosed if there is evidence of decreased kidney function (eGFR), kidney damage (elevated uACR) or both for **at least three months**. It is important to use the appropriate ICD-10 code to classify CKD severity and avoid using CKD unspecified code, when possible.

For more information, refer to the ***Kidney Health Evaluation for Patients with Diabetes* tip sheet** or 2024 *Kidney Health Evaluation for Patients with Diabetes Network Performance Improvement* presentation. Here's how to find them.

1. Log in to our provider portal (**availity.com**).
2. Click *Payer Spaces* on the menu bar and then click the BCBSM and BCN logo.
3. Click the *Resources* tab.
4. Click *Secure Provider Resources* (*Blue Cross and BCN*).
5. Click *Member Care* on the menu bar and then click *Clinical Quality* and *Tip Sheets* for the tip sheet or *Clinical Quality Overview* for the presentation.

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

Medical policy updates

Blue Care Network's medical policies are posted on **bcbsm.com/providers**. To find them:

1. Go to **bcbsm.com/providers**.
2. Click *Resources* in the top navigation.
3. Click the *Search Medical Policies* button.

Recent updates to the medical policies include:

Covered services

- Analysis of human FIT-DNA (i.e., ColoGuard®) in stool samples as a technique for colorectal cancer screening
- Assisted reproductive techniques
- Genetic testing for Amyotrophic Lateral Sclerosis
- Genetic testing-noninvasive prenatal screening for fetal aneuploidies, microdeletions, single-gene disorders and twin zygosity using cell-free fetal DNA
- Germline and somatic biomarker testing (including liquid biopsy) for targeted treatment in prostate cancer (BRCA1/2, homologous recombination repair gene alterations)
- Obstructive sleep apnea - non-surgical treatment
- Obstructive sleep apnea and snoring - surgical treatment
- Prostate cancer early detection: Biomarkers prior to biopsy
- Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiotherapy (SBRT)
- Telemonitoring-remote patient monitoring and remote therapeutic monitoring
- Vagus nerve stimulation

Noncovered services

- Computer-aided evaluation as an adjunct to magnetic resonance imaging for prostate cancer
- Digital health technologies therapeutic applications
- Microcurrent Electrical Neurostimulation (MENS)
- Remote Electrical Neuromodulation (REN) for migraines

Medical Policy Updates

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

Register now for our virtual Behavioral Health Summit

Professional behavioral health providers and billers are invited to our upcoming virtual Behavioral Health Summit. Attendees can interact with Provider Engagement & Transformation consultants, receive tailored presentations from various behavioral health-specific departments and network with peers and industry leaders. The summit will be held virtually on Thursday, Aug. 8.

Session date/time	Time	Registration
Thursday, Aug. 8 (virtual only)	Noon - 2:00 p.m. Eastern time	**Register here**

For more information about the summit, contact **providerengagement@bcbsm.com**.

Screening for and managing diabetes and high cholesterol risk from antipsychotic medications

Antipsychotic medications are essential for managing various psychiatric disorders, but they can also lead to metabolic side effects such as diabetes and high cholesterol. Screening for and managing these conditions is crucial to ensure the overall health and well-being of patients on antipsychotic therapy.

Patients on antipsychotic medications should undergo regular screening for diabetes due to the increased risk associated with these drugs. Fasting blood glucose levels, HbA1c tests and oral glucose tolerance tests are recommended screening methods. Early detection allows for timely intervention and management to prevent complications.

For patients diagnosed with diabetes while on antipsychotic therapy, a multidisciplinary approach is essential. Collaborating with endocrinologists, dietitians and mental health professionals can help optimize diabetes management while addressing the psychiatric needs of the patient. Lifestyle modifications, medication adjustments and close monitoring are key components of diabetes management in this population.

Elevated cholesterol levels are also a common side effect of antipsychotic medications and can increase the risk of cardiovascular disease. Regular lipid profile screenings are recommended to monitor cholesterol levels. Lifestyle modifications, such as dietary changes and exercise, should be encouraged to help manage high cholesterol.

In cases where patients develop high cholesterol while on antipsychotic therapy, a comprehensive approach is necessary. Statin therapy may be considered in consultation with a cardiologist to lower cholesterol levels and reduce cardiovascular risk. Monitoring lipid profiles regularly is crucial to assess the effectiveness of treatment.

Screening for and managing diabetes and high cholesterol in patients taking antipsychotic medications is vital to prevent long-term complications and improve overall health outcomes. Healthcare providers should be vigilant in monitoring metabolic parameters in this population to provide comprehensive care that addresses both psychiatric and physical health needs.

References

1. Pillinger, T., McCutcheon, R. A., Vano, L., Mizuno, Y., Arumuham, A., & Hindley, G. (2019, December 17). ***Comparative effects of 18 antipsychotics on metabolic function in patients with schizophrenia, predictors of metabolic dysregulation, and association with psychopathology: a systematic review and network meta-analysis***. The Lancet - Psychiatry.

2. Carnovale C, Lucenteforte E, Battini V, et al. ***Association between the glyco-metabolic adverse effects of antipsychotic drugs and their chemical and pharmacological profile: a network meta-analysis and regression***. Psychological Medicine. 2022; 52(15):3508-3520.

3. Stogios, N., Smith, E., Bowden, S., Tran, V., Asgariroozbehani, R., McIntyre, W. B., Remington, G., Siskind, D., Agarwal, S. M., & Hahn, M. K. (2021, August 26). ***Metabolic adverse effects of off-label use of second-generation antipsychotics in the adult population: a systematic review and meta-analysis***. Nature News.

4. Chang SC, Goh KK, Lu ML. *Metabolic disturbances associated with antipsychotic drug treatment in patients with schizophrenia: State-of-the-art and future perspectives*. World J Psychiatry. 2021 Oct 19;11(10):696-710. doi: 10.5498/wjp.v11.i10.696. PMID: 34733637; PMCID: PMC8546772.

Guidelines for using the *Autism diagnostic evaluation results form*

Members can obtain an autism evaluation using one of the methods described in the document ***Obtaining an autism diagnostic evaluation and finding treatment***.

If you choose to record the results of the autism evaluation on the ***Autism diagnostic evaluation results form***, follow these guidelines:

- Use only the current version of the form, which is dated Jan. 1, 2024, or later. Older versions include fax numbers that should no longer be used.
- Record the diagnosis on the form, even if it isn't an autism diagnosis.
- Don't fax the form. Give it to the member or to the member's parent or guardian along with the components of the evaluation. The member should give the form and the evaluation components to the treating practitioner.

  Note: We're still receiving the older forms from approved autism evaluation centers. Faxing these forms to Blue Cross and BCN — instead of giving them to the member or to the member's parent or guardian — can delay the members getting the treatment they need.
- If you're the treating provider, submit the form and the evaluation components to Blue Cross Behavioral Health℠ when you request prior authorization.

We've updated the document ***Blue Cross Behavioral Health: Frequently asked questions for providers*** to include this information. Providers can access that document on our **ereferrals.bcbsm.com** website, on these pages:

- **Blue Cross Autism**
- **BCN Autism**
- **Blue Cross Behavioral Health**
- **BCN Behavioral Health**

Prior authorization no longer required for autism-related PT, OT, ST and physical medicine services for BCN commercial members

Autism-related physical, occupational and speech therapy by therapists and physical medicine services by athletic trainers and chiropractors no longer require prior authorization for BCN commercial members 19 and older. We've updated our processes to reflect this change.

Please don't submit prior authorization requests to eviCore healthcare for these services when they're related to an autism diagnosis.

We updated our communications to reflect this change.

eviCore healthcare is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services. For more information, go to our **ereferrals.bcbsm.com** website.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *New mini modules available to help you navigate the Blue Cross behavioral health provider portal,* **Page 5**
- *New on-demand training available: Check out our latest learning path,* **Page 5**

Pharmacy News

AllianceRx Walgreens Pharmacy will become Walgreens Specialty Pharmacy on August 1

Effective August 1, 2024, AllianceRx Walgreens Pharmacy, a provider of specialty pharmacy services, will become Walgreens Specialty Pharmacy.

Walgreens Specialty Pharmacy will continue to provide Blue Cross Blue Shield of Michigan, Blue Care Network commercial and Medicare Advantage members with specialty medications used to treat chronic, complex or rare conditions.

Members are being notified of the name change through their prescription orders, which started in May. They can continue to call **1-866-515-1355** should they have questions about their specialty medications.

Send prescriptions to Walgreens Specialty Pharmacy by:

- Phone: **1-866-515-1355**
- Fax: **1-866-515-1356**
- Electronically/E-prescribing name: Walgreens Specialty Pharmacy – MICHIGAN

Use modifiers JW and JZ when billing Part B medical benefit drug claims

To receive timely and appropriate payment of Part B claims for Medicare Plus Blue℠ and BCN Advantage℠ members, health care providers, facilities and suppliers must include the JW or JZ modifier when billing for single-dose vials or other single-use packages of Part B drugs. This doesn't apply to multi-use vials or other multi-use packages.

For claims submitted on or after Oct. 1, 2023, the Centers for Medicare & Medicaid Services requires health plans to return claims without processing them when claim lines don't include the appropriate modifiers. The claims must then be resubmitted with the appropriate modifiers. This applies to all providers, facilities and suppliers who buy and bill separately payable single-container drugs under Medicare Part B.

Here's how to use these HCPCS Level II modifiers:

- The **JW modifier** is required when reporting the amount of drug that is discarded and is eligible for payment under the discarded drug policy.

  Example: A single-use vial that is labeled to contain 100 units of a drug has 95 units administered to the member and five units discarded. The 95-unit dose is billed on line one, while the discarded five units are billed on line two using the JW modifier. Both line items are processed for payment. Providers must record the discarded amounts of drugs and biologicals in the member's medical record.
- The **JZ modifier** is used to attest that no amount of drug was discarded.

Here's what you need to include on these claims:

Type of claim	What to do
Waste-related claim (JW modifier)	Submit two complete claim lines. Include the following information. **Line 1:** • HCPCS code for the drug administered • Number of units administered to the member (in the example above, you'd enter 95 units) • Calculated price for only the amount administered to the member **Important:** Don't include a modifier on line 1. **Line 2:** • HCPCS code for the drug that was wasted • JW modifier to indicate waste • Number of units wasted (in the example above, you'd enter 5 units) • Calculated price for only the amount of drug wasted
Claim with no waste — Entire amount of drug is administered (JZ modifier)	Submit one claim line. Include the following information: • HCPCS code for the drug administered • JZ modifier to indicate there was no waste • Number of units administered to the member • Calculated price for the amount of drug administered

For additional information, see the **CMS Billing and Coding: JW and JZ Modifier Billing Guidelines** page on **cms.gov**.

Elrexfio, Talvey require prior authorization for most members, starting June 20

For dates of service on or after June 20, 2024, the following drugs require prior authorization through the Oncology Value Management program:

- Elrexfio™ (elranatamab-bcmm), HCPCS code J1323
- Talvey™ (talquetamab-tgvs), HCPCS code J3055

The Oncology Value Management program is administered by Carelon Medical Benefits Management. These drugs are part of members' medical benefits, not their pharmacy benefits.

Prior authorization requirements apply when these drugs are administered in outpatient settings for:

- Blue Cross Blue Shield of Michigan commercial:
  - All fully insured members (group and individual).
  - Members who have coverage through **self-funded groups that have opted in to the Oncology Value Management program**.

    Although UAW Retiree Medical Benefits Trust non-Medicare plans have opted into this program, these requirements may not apply. Refer to their medical oncology drug list, which is linked below.

    Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue℠ members
- Blue Care Network commercial members
- BCN Advantage℠ members

How to submit prior authorization requests

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

- Go through the Carelon provider portal, which you can access by doing one of the following:
  - Logging in to our provider portal (**availity.com**), clicking *Payer Spaces* and then clicking the BCBSM and BCN logo. This takes you to the Blue Cross and BCN payer space, where you'll click the *Carelon Provider Portal* tile.

    Note: If you need to request access to our provider portal, see the ***Register for web tools webpage*** on **bcbsm.com**.
  - Logging in directly to the Carelon provider portal at **providerportal.com**.
- Call the Carelon Contact Center at **1-844-377-1278**.

Drug lists

For additional information on requirements related to drugs covered under the medical benefit, refer to the following drug lists:

- Blue Cross commercial and BCN commercial
  - **Oncology Value Management program prior authorization list for Blue Cross and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- URMBT members with Blue Cross non-Medicare plans
  - **Oncology Value Management program prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
  - **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare Members**
- Medicare Plus Blue and BCN Advantage members:
  - **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

As a reminder, prior authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

Pharmacy News

Step therapy requirement to be added for VPRIV, Elelyso for Medicare Advantage members, starting June 1

For dates of service on or after June 1, 2024, health care providers must show that Medicare Plus Blue℠ and BCN Advantage℠ members tried and failed Cerezyme® (imiglucerase) when requesting prior authorization for the following drugs:

- VPRIV® (velaglucerase alfa), HCPCS code J3385
- Elelyso® (taliglucerase alfa), HCPCS code J3060

Cerezyme is Blue Cross Blue Shield of Michigan and Blue Care Network's preferred enzyme replacement therapy for Gaucher disease.

These drugs are covered under members' medical benefits, not their pharmacy benefits.

Providers should submit prior authorization requests for VPRIV and Elelyso through the NovoLogix® online tool.

As a reminder, Cerezyme doesn't require prior authorization for dates of service on or after Jan. 1, 2024.

When prior authorization is required

VPRIV and Elelyso require prior authorization when they are administered by a provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or using the UB04 claim form for a hospital outpatient type of bill 013X

Submit prior authorization requests through NovoLogix

To access NovoLogix, log in to our provider portal at **availity.com**, click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the *Applications* tab.

If you need to request access to our provider portal, follow the instructions on the ***Register for web tools*** page on **bcbsm.com**.

List of requirements

For a list of requirements related to drugs covered under the medical benefit, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**.

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

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Columvi, Daxxify, Qalsody to require prior authorization for URMBT members with Blue Cross non-Medicare plans

For dates of service on or after July 1, 2024, the drugs listed below will require prior authorization for UAW Retiree Medical Benefits Trust members with Blue Cross Blue Shield of Michigan non Medicare plans.

These drugs are part of members' medical benefits, not their pharmacy benefits.

See the table below for:

- Drug names and HCPCS codes
- Where to submit prior authorization requests

Brand name	Generic name	HCPCS code	Submit requests through
Columvi™	Glofitamab-gxbm	J9286	Carleon Medical Benefits Management provider portal
Daxxify®	Daxibotulinum toxinA-lanm	J0589	NovoLogix® online tool
Qalsody™	Tofersen	J1304	NovoLogix online tool

The prior authorization requirement applies apply only when these drugs are administered in an outpatient setting.

Note: The requirement doesn't apply to the UAW Retiree Health Care Trust (group number 70605) or the UAW International Union (group number 71714).

How to submit prior authorization requests

To access the Carelon provider portal or the NovoLogix online tool, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. On the Applications tab, click the tile for the Carelon provider portal or the appropriate NovoLogix tool.

If you need to request access to our provider portal, see the ***Register for web tools*** webpage on **bcbsm.com**.

You can also log in directly to the Carelon provider portal at **providerportal.com**.

More about requirements for medical benefit drugs

For additional information on requirements related to drugs covered under the medical benefit for URMBT members with Blue Cross non-Medicare plans, see:

- **Medical oncology prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
- **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare Members**

We'll update the drug lists to reflect the information in this article prior to the effective date.

As a reminder, prior authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage authorizations for select services.

Cinryze, Elfabrio, Evkeeza to have site-of-care requirement for most commercial members, starting July 1

For dates of service on or after July 1, 2024, we're adding a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drugs covered under the medical benefit:

- Cinryze® (c-1 esterase), HCPCS code J0598
- Elfabrio® (pegunigalsidase alfaiwxj), HCPCS code J2508
- Evkeeza® (evinacumab-dgnb), HCPCS code J1305

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for these drugs. If the request meets the clinical criteria for the drug and is for one of the following sites of care, it will be approved automatically:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

Additional information or documentation may be required for requests to administer Cinryze, Elfabrio and Evkeeza in an outpatient hospital setting.

As a reminder, these drugs already require prior authorization; providers can submit prior authorization requests using NovoLogix. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who start courses of treatment with Cinryze, Elfabrio or Evkeeza before July 1, 2024, will be able to continue receiving the drug in their current location until their existing authorization expires. If these members then continue treatment under a new prior authorization, the site-of-care requirement outlined above will apply.

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

For Blue Cross commercial groups, prior authorization and site-of-care requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

List of requirements

For a full list of requirements related to drugs covered under the medical benefit, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**. We'll update this list prior to the effective date.

You can access this list and other information about requesting prior authorization at **ereferrals.bcbsm.com**, at these locations:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

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

Vyjuvek has a site-of-care requirement for most commercial members

For dates of service on or after April 4, 2024, we added a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Vyjuvek™ (beremagene geperpavec-svdt), HCPCS code J3401

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for this drug. If the request meets the clinical criteria for the drug and is for one of the following sites of care, it will be approved automatically:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

Additional information or documentation may be required for requests to administer Vyjuvek in an outpatient hospital setting.

This drug already requires prior authorization; providers can submit prior authorization requests using NovoLogix. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who started courses of treatment with Vyjuvek before April 4, 2024, will be able to continue receiving the drug in their current location until their existing authorization expires. If these members then continue treatment under a new prior authorization, the site-of-care requirement outlined above will apply.

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

For Blue Cross commercial groups, prior authorization and site-of-care requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

List of requirements

For a full list of requirements related to drugs covered under the medical benefit, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**. We've updated this list to reflect the Vyjuvek change.

You can access this list and other information about requesting prior authorization at **ereferrals.bcbsm.com**, at these locations:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

BCN Provider *News*
Feedback

Amtagvi has additional requirements for most commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network updated the medical policy for Amtagvi™ (lifileucel). The requirements in the updated medical policy apply for most Blue Cross and BCN commercial members for dates of service on or after May 28, 2024.

The following additional requirements must be met for treatment with Amtagvi to be considered medically necessary:

- Members haven't received prior treatment:
  - With any tumor infiltrating lymphocyte, or TIL, therapy despite indication.
  - With any other genetically modified TIL therapy and aren't being considered for treatment with any other genetically modified TIL therapy.
- The treatment must be administered at a certified TIL treatment center.

You can see the full list of requirements in the updated medical policy. To view the policy, go to the **Medical Policy Router Search** page, enter the name of the drug in the *Policy/Topic Keyword* field and press *Enter*.

To access the Medical Policy Router Search page, go to **bcbsm.com/providers**, click *Resources* and then click *Search Medical Policies*.

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

Additional information

For additional information about drugs covered under the medical benefit, see the following pages of the **ereferrals.bcbsm.com** website:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

Cosentyx IV to have a site-of-care requirement for most commercial members starting July 1

For dates of service on or after July 1, 2024, we're adding a site-of-care requirement for Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Cosentyx® IV (secukinumab), HCPCS code J3590

The NovoLogix® online tool will prompt you to select a site of care when you submit prior authorization requests for this drug. If the request meets the clinical criteria for the drug and is for one of the following sites of care, it will be approved automatically:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

Additional information or documentation may be required for requests to administer Cosentyx IV in an outpatient hospital setting.

As a reminder, this drug already requires prior authorization; providers can submit prior authorization requests using NovoLogix. The new site-of-care requirement is in addition to the current prior authorization requirement.

Members who start courses of treatment with Cosentyx IV before July 1, 2024, will be able to continue receiving the drug in their current location until their existing authorization expires. If these members then continue treatment under a new prior authorization, the site-of-care requirement outlined above will apply.

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

For Blue Cross commercial, prior authorization and site-of-care requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

List of requirements

For a full list of requirements related to drugs covered under the medical benefit, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**. We'll update this list prior to the effective date.

You can access this list and other information about requesting prior authorization at **ereferrals.bcbsm.com**, at these locations:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

Omvoh SC and IV have a step therapy requirement for most commercial members

For dates of service on or after June 3, 2024, members must try and fail four preferred products before we'll approve prior authorization requests for Omvoh™ SC and IV (mirikizumab-mrkz), HCPCS code J3590.

The four preferred products for Omvoh SC and IV are:

Brand name (generic name)	Benefit under which drug may be covered
Humira® (adalimumab)	Pharmacy
Simponi® (golimumab)	Pharmacy
Stelara® SC (ustekinumab)	Pharmacy and medical
Xeljanz/XR® (tofacitinib) **or** Rinvoq® (upadacitinib)	Pharmacy

For the preferred products, providers need to comply with any requirements, such as prior authorization, which applies under the applicable benefit.

For Omvoh SC and IV:

- The step therapy requirement applies to most Blue Cross Shield of Michigan and Blue Care Network group and individual commercial members.
- Providers should continue to submit prior authorization requests through the NovoLogix® online tool.

We'll update the **Blue Cross and BCN utilization management medical drug list** to reflect the preferred drugs.

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group list**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

Additional information

For more information about medical benefit drugs, see the following pages on **ereferrals.bcbsm.com**:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

Spevigo SC has requirements for most commercial members

For dates of service on or after April 25, 2024, we added prior authorization and site-of-care requirements for most Blue Cross Blue Shield of Michigan and Blue Care Network group and individual commercial members for the following drug covered under the medical benefit:

- Spevigo® SC (spesolimab-sbzo), HCPCS code J1747

How to submit prior authorization requests

Submit prior authorization requests through the NovoLogix® online tool. It offers real-time status checks and immediate approvals for certain medications.

To access NovoLogix, log in to our provider portal at **availity.com**, click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, see the ***Register for web tools*** webpage on **bcbsm.com**.

The NovoLogix online tool will prompt you to select a site of care when you submit prior authorization requests for this drug. If the request meets clinical criteria for the drug and is for one of the following sites of care, it will be approved automatically:

- Doctor's or other health care provider's office
- Ambulatory infusion center
- The member's home, from a home infusion therapy provider

Additional information or documentation may be required for requests to administer Spevigo in an outpatient hospital setting.

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

For Blue Cross commercial, these requirements apply only to groups that participate in the standard commercial Medical Drug Prior Authorization Program for drugs administered under the medical benefit. To determine whether a group participates in the prior authorization program, see the **Specialty Pharmacy Prior Authorization Master Opt-in/out Group List**.

Note: Blue Cross and Blue Shield Federal Employee Program® members and UAW Retiree Medical Benefits Trust (non-Medicare) members don't participate in the standard prior authorization program.

List of requirements

For a full list of requirements related to drugs covered under the medical benefit, see the **Blue Cross and BCN utilization management medical drug list for Blue Cross commercial and BCN commercial members**. We've updated this list to reflect the Spevigo SC changes.

You can access this list and other information about requesting prior authorization on the following pages of the **ereferrals.bcbsm.com** website:

- **Blue Cross Medical Benefit Drugs**
- **BCN Medical Benefit Drugs**

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

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Additional drugs to have a site-of-care requirement for some commercial members starting Aug. 1

For dates of service on or after Aug. 1, 2024, the following medical benefit drugs will have a site-of-care requirement for some Blue Cross Blue Shield of Michigan and all Blue Care Network group and individual commercial members:

Brand name	Generic name	HCPCS code
Darzalex Faspro™	daratumumab and hyaluronidase-fihj	J9144
Herceptin Hylecta™	trastuzumab and hyaluronidase-oysk	J9356
Kanjinti™	trastuzumab-anns	Q5117
Mvasi™	bevacizumab-awwb	Q5107
Ogivri®	trastuzumab-dkst	Q5114
Perjeta®	pertuzumab	J9306
Phesgo™	pertuzumab, trastuzumab and hyaluronidase–zzxf	J9316
Rituxan Hycela®	rituximab-hyaluronidase human	J9311

When the site-of-care requirement goes into effect, these drugs may be covered only when administered at the following sites of care:

- Doctor's or other health care provider's office
- The member's home, administered by a home infusion therapy provider
- Ambulatory infusion center

These drugs already require prior authorization through the Oncology Value Management program, administered by Carelon Medical Benefits Management. The new site-of-care requirement is in addition to any current prior authorization requirements.

Commercial members affected by this change

- Blue Cross commercial:
  - All fully insured members (group and individual), with the exception of MESSA members.
  - Members who have coverage through **self-funded groups that have opted in to the Oncology Value Management program**. (Although UAW Retiree Medical Benefits Trust non-Medicare plans have opted in to this program, the site-of-care requirement doesn't apply.)

    Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- All Blue Care Network commercial members

How the site-of-care requirement will be phased in

The site-of-care requirement will apply as follows for infusions involving the drugs listed above:

- **For courses of therapy starting on or after Aug. 1, 2024:** These infusions may not be covered at outpatient hospital facilities.
- **For courses of therapy that start before and continue beyond Aug. 1, 2024:** These infusions may not be covered at outpatient hospital facilities starting Nov. 1, 2024. To continue treatment at an outpatient hospital facility, you'll need to submit a prior authorization request to Carelon for approval prior to Nov. 1.

Please see Site-of-care requirement continued on Page 25

Site-of-care requirement, *continued from Page 24*

What to do for members who currently receive these drugs

For Blue Cross and BCN commercial members who currently receive these drugs at an outpatient hospital facility:

- Locate an in-network home infusion therapy provider or ambulatory infusion center at which the member may be able to continue their infusion therapy.
- Discuss with the member how to facilitate receiving their infusions at an allowed site of care.

For Blue Cross and BCN commercial members who currently receive these drugs at a provider's office, at home or in an ambulatory infusion center, no action is required.

How we'll help

For members who need to transition to a new infusion location, we'll work with you and the member to facilitate the transition. We'll notify members and encourage them to talk to you before changing their infusion location. We'll also let them know that the change of location doesn't affect the treatment you're providing.

List of requirements

- To view requirements for drugs covered under the medical benefit, refer to the ***Blue Cross and BCN utilization management medical drug list*** for Blue Cross and BCN commercial members. We'll update this list prior to the effective date on Aug. 1
- You can access this list and other information about submitting prior authorization requests to Carelon at **ereferrals.bcbsm.com** on the following pages:
  - **Blue Cross Medical Benefit Drugs**
  - **BCN Medical Benefit Drugs**

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage authorizations for select services.

Pemfexy and Pemrydi RTU to have additional step therapy requirements for most members

Members must try and fail two other pemetrexed drugs before we'll approve prior authorization requests for Pemfexy® or Pemrydi RTU®. For the details, refer to this table:

Nonpreferred product	Step therapy requirement	For dates of service on or after
Pemfexy (pemetrexed), HCPCS code J9304)	Must try and fail at least two of the preferred products listed below.	April 26, 2024
Pemrydi RTU (pemetrexed), HCPCS code J9324	Must try and fail at least two of the preferred products listed below.	Aug. 1, 2024

The preferred products are:

- Alimta® (pemetrexed), HCPCS code J9305
- Pemetrexed (generic, various brands), HCPCS codes J9294, J9296, J9297, J9314, J9322 and J9323
- Pemrydi RTU, for dates of service from April 26 through July 31, 2024

  Note: For dates of service on or after Aug. 1, Pemrydi RTU will no longer be a preferred product, as indicated in the table above.

These drugs are covered under members' medical benefits, not their pharmacy benefits.

All of the drugs listed above continue to require prior authorization through the Carelon provider portal, as specified in the pertinent drug lists linked below. We'll update these lists to reflect the new step therapy requirement prior to the effective date.

Members affected by this change

This requirement applies to the following members:

- Blue Cross Blue Shield of Michigan commercial
  - All fully insured members (group and individual).
  - Members who have coverage through **self-funded groups that have opted in to the Carelon medical oncology program**. This includes members who have UAW Retiree Medical Benefits Trust non-Medicare plans.

    Note: This requirement doesn't apply to members who have coverage through the Blue Cross and Blue Shield Federal Employee Program®.
- Medicare Plus Blue
- Blue Care Network commercial
- BCN Advantage

More about the prior authorization requirements

For additional information on requirements related to drugs covered under the medical benefit, refer to the following drug lists:

- Blue Cross commercial and BCN commercial
  - **Oncology Value Management prior authorization list for Blue Cross and BCN commercial members**
  - **Blue Cross and BCN utilization management medical drug list**
- URMBT members with Blue Cross non-Medicare plans
  - **Oncology Value Management program prior authorization list for UAW Retiree Medical Benefits Trust PPO non-Medicare members**
  - **Medical Drug Management with Blue Cross for UAW Retiree Medical Benefits Trust PPO non-Medicare Members**
- Medicare Plus Blue and BCN Advantage
  - **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**

As a reminder, prior authorization isn't a guarantee of payment. Health care practitioners need to verify eligibility and benefits for members.

Carelon Medical Benefits Management is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to manage prior authorizations for select services.

Step therapy requirement added for botulinum toxins for Medicare Advantage members starting Aug. 5

For dates of service on or after Aug. 5, 2024, providers will have to show that our Medicare Plus Blue℠ and BCN Advantage℠ members tried and failed Xeomin® (incobotulinum toxin A), HCPCS code J0588, when requesting prior authorization for the following drugs:

- Botox® (onabotulinumtoxin A), HCPCS code J0585
- Dysport® (abobotulinumtoxin A), HCPCS code J0586
- Daxxify® (daxibotulinumtoxin A), HCPCS code J0589
- Myobloc® (rimabotulinum toxin B), HCPCS code J0587

Xeomin is the preferred botulinum toxin product for Medicare Plus Blue and BCN Advantage members.

Here's other important information:

- Step therapy with Xeomin won't be required for requests to treat chronic migraines or urinary conditions such as overactive bladder.
- Xeomin won't require prior authorization for dates of service on or after June 1, 2024. For dates of service before June 1, submit prior authorization requests through the NovoLogix® online tool.
- Submit prior authorization requests for Botox, Dysport, Myobloc and Daxxify through NovoLogix.

These drugs are a part of members' medical benefits, not their pharmacy benefits.

When prior authorization is required

These drugs require prior authorization, as applicable, when they're administered by a health care provider in sites of care such as outpatient facilities or physician offices and are billed in one of the following ways:

- Electronically through an 837P transaction or on a professional CMS-1500 claim form
- Electronically through an 837I transaction or using the UB04 claim form for a hospital outpatient type of bill 013x

Submit prior authorization requests through NovoLogix

To access NovoLogix, log in to our provider portal (**availity.com**), click *Payer Spaces* in the menu bar and then click the BCBSM and BCN logo. You'll find links to the NovoLogix tools on the Applications tab.

Note: If you need to request access to our provider portal, follow the instructions on the ***Register for web tools*** webpage at **bcbsm.com/providers**.

List of requirements

For a list of requirements related to drugs covered under the medical benefit, see the **Medical Drug and Step Therapy Prior Authorization List for Medicare Plus Blue and BCN Advantage members**.

We'll update this list prior to the effective date.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

BCN Provider News
Feedback

An ongoing series of quick tips designed to be read in 60 seconds or less and provide your practice with information about performance in key areas.

Statins

- Once patients demonstrate they can tolerate statin therapy, encourage them to obtain 90-day supplies through their pharmacy or mail-order pharmacy. Members can sign up for OptumRx home delivery online at **optumrx.com** or by calling 1-855-810-0007.
- Statin quality measures are dependent on pharmacy claims and patients must fill their prescriptions using their pharmacy benefit to count toward gap closure. Discount programs, VA benefits, cash claims and medication samples **don't** count toward quality measures.
- To exclude patients who can't tolerate statin medications, a claim **must** be submitted **annually** using the appropriate diagnosis code. Diagnoses that exclude members from statin measures can be found in the statin tip sheets.

For more information, refer to the ***Statin Therapy for Patients with Cardiovascular Disease (SPC)***, ***Statin Use in Persons with Diabetes (SUPD)*** and *Statin Therapy for Patients with Diabetes (SPD)* tip sheets. Here's how to find them.

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

OptumRx is an independent company that processes prescription claims and prior authorizations for services provided under the pharmacy benefit for Blue Cross Blue Shield of Michigan and Blue Care Network members.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

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

- *How to protect yourself against health care fraud,* **Page 3**
- *Tips to help administrators keep patients' information secure,* **Page 4**
- *Changes coming for select weight loss drugs for some commercial members,* **Page 37**

Billing Bulletin

BCN Provider *News*

Feedback

We're granting a 90-day extension to the time limit for commercial claim submission

Recognizing that many providers were affected by the recent Change Healthcare incident, Blue Cross Blue Shield of Michigan and Blue Care Network are granting a 90 day extension to the claim submission time limits for Blue Cross and BCN commercial claims. This includes primary original claims submitted on or after Feb. 22, 2024.

The 90-day extension ends Sept. 30, 2024. For all primary original claims submitted on or after Oct. 1, 2024, existing participation or affiliation agreement submission deadlines will apply.

The 90-day claim submission extension applies only to claims for Blue Cross commercial and BCN commercial. It doesn't apply to Medicare Advantage (Medicare Plus Blue℠ or BCN Advantage℠), Medicare Supplement or other secondary claims.

All audit rights and other plan rules still apply.

Thank you for your continued care of our members who are your patients.

Blue Cross, BCN to begin reimbursing E/M when billed with preventive service

Blue Cross Blue Shield of Michigan and Blue Care Network will begin reimbursing for evaluation and management, or E/M, services at 50% of the allowed amount when billed on the same day as a preventive service (see list). The preventive service will pay in full. This is a change from Blue Cross and BCN's current policy that only pays for the preventive service.

When two services are done on the same day, the modifier 25 must be billed with the E/M code or it won't be paid.

This reimbursement change will begin with dates of service beginning June 1, 2024. If a denial occurs while the claim system is being updated, resubmit your claim after the update is complete. The update is expected to be completed in late June. Do not submit an appeal for dates of service after June 1.

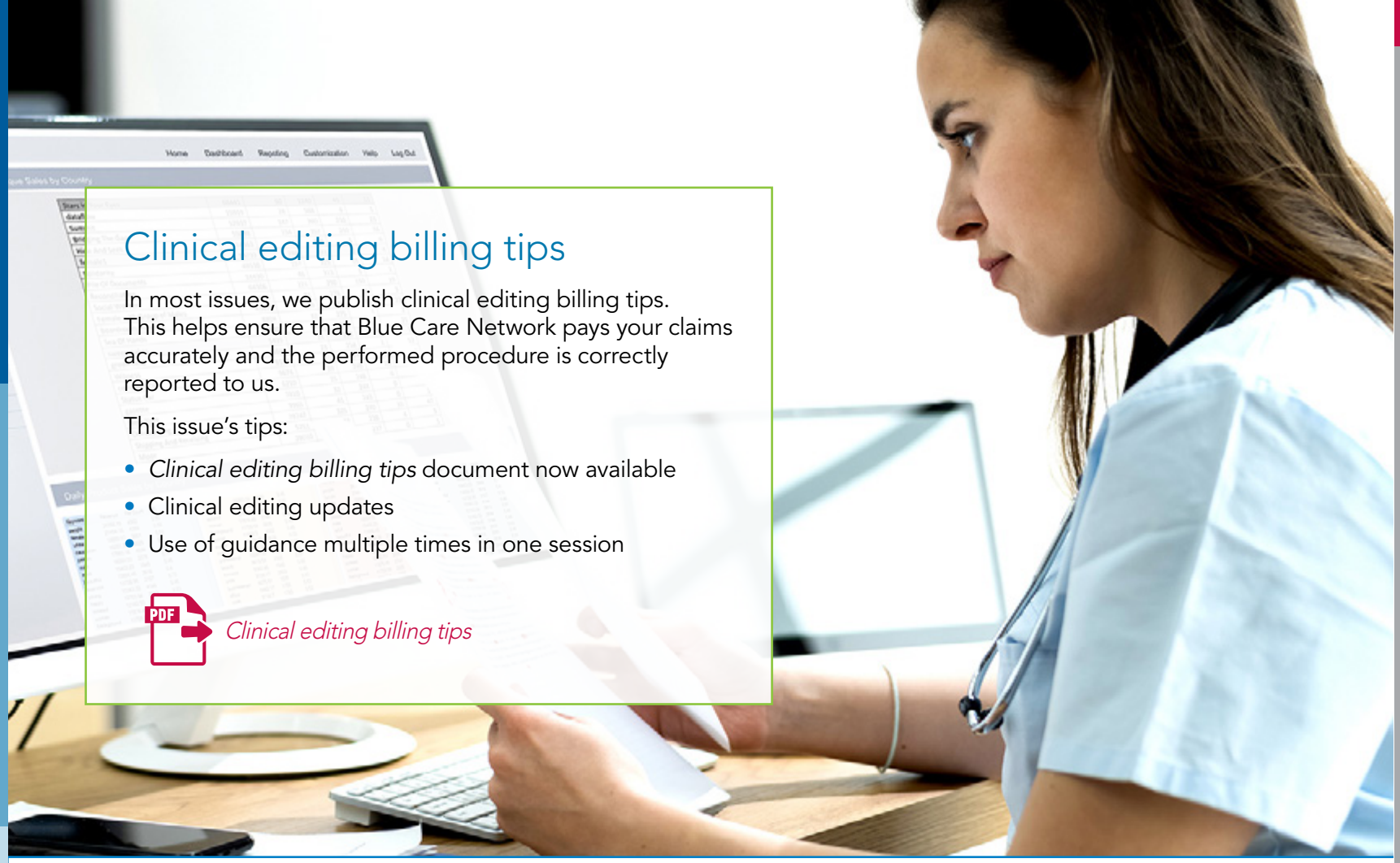
E&M Codes reimbursed at 50%

- *99202 – 99205
- *99211 – 99215
- *99341 – 99345
- *99347 – 99350

Preventive Codes

- *99381 – 99387
- *99391 – 99397
- *99401 – 99404
- *99406 – 99409
- *99411 – 99412
- S0610
- S0612-S0613

Billing Bulletin



Clinical editing billing tips

In most issues, we publish clinical editing billing tips. This helps ensure that Blue Care Network pays your claims accurately and the performed procedure is correctly reported to us.

This issue's tips:

- *Clinical editing billing tips* document now available
- Clinical editing updates
- Use of guidance multiple times in one session

Clinical editing billing tips

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

TurningPoint opens peer-to-peer reviews to advanced practice providers for musculoskeletal and pain management procedures

TurningPoint Healthcare Solutions LLC is now scheduling peer-to-peer reviews with advanced practice providers, or APPs (physician assistants and nurse practitioners). The APP peer-to-peer review process is available for participating orthopedic, pain management and spinal surgical practices that are contracted with Blue Cross Blue Shield of Michigan, Blue Care Network or both.

TurningPoint made this change to enable APPs to support physicians in the peer-to-peer review process. APPs can participate in peer-to-peer reviews related to routine prior authorization denials specific to coding, medical policy and documentation requirements for knee, ankle, shoulder, hip, elbow, wrist, spine and pain management procedures.

Reviews will be conducted by providers of the same provider type. For example, if the requesting provider is a physician assistant, the review discussion will be scheduled with a physician assistant at TurningPoint.

If you have questions about which cases are eligible for APP peer-to-peer reviews, contact the TurningPoint Provider Relations team at **providersupport@turningpoint-healthcare.com**.

We recently posted the following TurningPoint documents to the *Musculoskeletal Services* and *Pain Management Services* pages on **ereferrals.bcbsm.com**. These documents are also available through the TurningPoint Provider Portal.

- **TurningPoint Peer to Peer Quick Reference Guide**
- **TurningPoint Advance Practice Practitioner (APP) Peer-to-Peer Process**

We updated the ***Musculoskeletal procedure authorizations: Frequently asked questions for providers*** document to reflect this change.

Note: Provider offices will continue to have access to specialty-matched physician-to-physician peer-to-peer reviews.

For more information about TurningPoint's Musculoskeletal Surgical Quality and Safety Management program, including information about which groups and members participate in the program, see the following pages on **ereferrals.bcbsm.com**:

- **Blue Cross Musculoskeletal Services**
- **Blue Cross Pain Management Services**
- **BCN Musculoskeletal Services**
- **BCN Pain Management Services**

TurningPoint Healthcare Solutions LLC is an independent company provides care review services for Blue Cross Blue Shield of Michigan and Blue Care Network.

Save time by submitting only required information about acute inpatient medical, surgical admissions

When health care providers submit a prior authorization request for an acute inpatient medical and surgical admission, they can save time by submitting only the information that's required for the request.

Refer to the table below for more information.

Type of information to submit or type of request	How to submit
Names of members admitted to the hospital	Use the e-referral system to submit a prior authorization request for each admission.
Names of members discharged from the hospital	For each member discharged: • If the case is still open in the e-referral system, enter the discharge date for the member. • If the case has closed because the authorized days have elapsed, you don't need to do anything.
Clinical information	• If the prior authorization request was approved in the e referral system, don't submit additional clinical information. • If the member needs additional days, use the e-referral system to request those days and attach the clinical information to the request.
Information on sick newborns **Note:** The authorization request is separate from the delivery.	Information about sick newborns **must** be faxed because those members can't be found in the e-referral system. Complete the **Acute inpatient hospital assessment form** and fax it to the correct fax number: • For Blue Cross Blue Shield of Michigan commercial, fax to 1-800-482-1713. • For Blue Care Network commercial, fax to 1-866-313-8433. For timely processing, include the pertinent clinical documentation. You can access the form on the **ereferrals.bcbsm.com** website, on these pages: • **Blue Cross Acute Inpatient Medical and Surgical Admissions** • **BCN Acute Inpatient Medical and Surgical Admissions**
Retroactive authorization requests for inpatient admissions that started as outpatient services	Use the e-referral system to submit a retroactive authorization request for each inpatient admission.
Adjustments in dates of service for procedures managed by vendors such as TurningPoint Healthcare Solutions LLC	Submit this information to the vendor that manages the procedure. For information about submitting requests to vendors, visit **ereferrals.bcbsm.com**.

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

Referral Roundup

BCN Provider *News*

Feedback

Changes coming to prior authorization process for post-acute care services for Medicare Advantage members

In fourth-quarter 2024, Home & Community Care (formerly known as naviHealth, Inc.) will no longer manage prior authorizations for post-acute care services for Medicare Plus Blue℠ and BCN Advantage℠ members.

Post-acute care services will continue to require prior authorization, but the prior authorizations will be managed by Blue Cross Blue Shield of Michigan and Blue Care Network.

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

- Training, which will include program requirements and more
- Updates to our provider communications and documents for this program

Home & Community Care is an independent company that manages prior authorizations for post-acute care services for Blue Cross Blue Shield of Michigan and Blue Care Network members who have Medicare Advantage plans.

Procedure codes that require prior authorization through BCN

We've removed the document titled *BCN-managed procedure codes that require authorization for Michigan providers*.

To determine whether a procedure code requires prior authorization from Blue Care Network, see the document titled **Procedure codes for which providers must request prior authorization**. This document provides a detailed list of CPT* codes and HCPCS codes for services that require prior authorization for most members. Procedure codes that are managed by BCN, "BCNA," "HMO" or "BCNA | HMO" appear in the *Lines of business* column and "e-referral" appears in the *Requests managed by* column.

We'll use 2024 InterQual criteria starting Aug. 1

On Aug. 1, 2024, Blue Cross Blue Shield of Michigan and Blue Care Network will start using 2024 InterQual® criteria to make determinations on prior authorization requests for the medical (non-behavioral health) services we manage for these members:

- Blue Cross commercial
- Medicare Plus Blue
- BCN commercial
- BCN Advantage

Note: If InterQual criteria are updated to correct known issues or errors, we'll use the updated criteria as soon as they're available.

Blue Cross and BCN also use Local Rules for post-acute care (inpatient rehabilitation, skilled nursing facility and long-term acute care) prior authorization requests. These Local Rules are modifications of InterQual criteria that we use in making determinations. You can access the Local Rules on the **Services that need prior authorization** page on **bcbsm.com**. We're updating that page to include the most current version of the Local Rules.

Refer to the table below for more specific information about which criteria we use in making determinations for various types of non-behavioral health prior authorization requests.

Criteria	Services
InterQual acute — Adult and pediatrics	• Inpatient admissions • Continued stay discharge readiness
InterQual level of care — Subacute and skilled nursing facility	• Subacute and skilled nursing facility admissions • Continued stay discharge readiness
InterQual rehabilitation — Adult and pediatrics	• Inpatient admissions • Continued stay and discharge readiness
InterQual level of care — Long-term acute care	• Long-term acute care facility admissions • Continued stay discharge readiness
InterQual imaging	Imaging studies and X-rays
InterQual procedures — Adult and pediatrics	Surgery and invasive procedures
Medicare coverage guidelines (as applicable)	Services that require clinical review for medical necessity and benefit determinations
Blue Cross and BCN medical policies	Services that require clinical review for medical necessity
Local Rules for post-acute care (applies to inpatient rehabilitation, skilled nursing facility and long-term acute care admissions for Blue Cross commercial and BCN commercial)	Exceptions to the application of InterQual criteria that reflect the accepted practice standards for Blue Cross and BCN

When clinical information is requested for a medical or surgical admission or for other services, we require providers to submit specific components of the medical record that show that the request meets the criteria. We review this information when making determinations on prior authorization requests.

Note: This information applies to members whose authorizations are managed by Blue Cross or BCN directly and not by independent companies that provide services to Blue Cross or BCN.

Questionnaire changes in the e-referral system

On March 31 and April 28, 2024, we added and updated questionnaires in the e-referral system.

We updated the **Authorization criteria and preview questionnaires** document on the **ereferrals.bcbsm.com** website to reflect these changes.

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

New questionnaire

On March 31, we added the following questionnaire to the e-referral system.

Questionnaire	Opens for	Updates
Endoscopic bypass E&I trigger	• BCN commercial • BCN Advantage	Opens for procedure codes *43644 and *43645.

Updated questionnaires

We updated the following questionnaires in the e-referral system on the date specified below.

Questionnaire	Opens for	Updates	Release date
Cosmetic or reconstructive surgery	BCN commercial	No longer opens for BCN Advantage or Medicare Plus Blue.	3/31/2024
Dental general anesthesia	BCN commercial	• No longer opens for BCN Advantage. • Updated two questions. • Removed one question.	3/31/2024
Dental general anesthesia or dental services trigger	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Dental services	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Excess skin removal	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Facial feminization surgery and chondrolaryngoplasty	BCN commercial	• The name of the questionnaire was changed to *Facial feminization surgery.* • The questionnaire no longer opens for procedure codes *21120, *21121, *21122, *21123, *21125, *21127, *21137, *21138, *21139, *21209, *30400, *30410, *30420 and *31559. However, these procedure codes continue to require prior authorization.	4/28/2024
Orthognathic surgery	BCN commercial	No longer opens for BCN Advantage.	3/31/2024
Responsive neurostimulator / deep brain stimulation trigger	• BCN commercial • BCN Advantage	Updated a question.	3/31/2024
Surgical treatment for male gynecomastia	• BCN commercial • BCN Advantage	Updated a question in the BCN commercial questionnaire.	3/31/2024

Please see Questionnaire changes continued on Page 36

Referral Roundup

Questionnaire changes,

continued from Page 35

Preview questionnaires

Preview questionnaires show the questions you'll need to answer in the e-referral system so you can prepare your answers ahead of time.

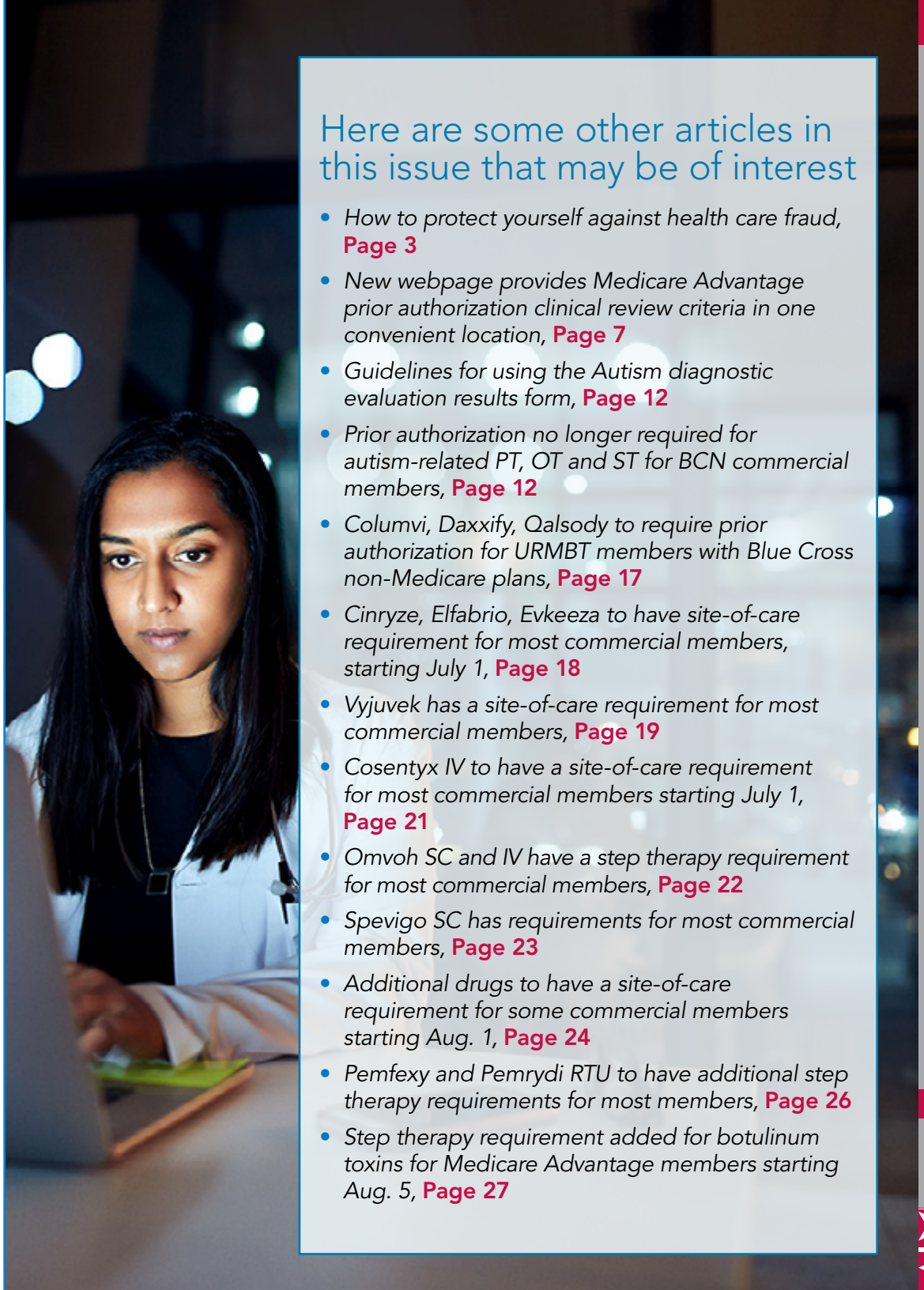
To find the preview questionnaires, see the document titled **Authorization criteria and preview questionnaires**.

You can access this document by going to **ereferrals.bcbsm.com** and doing the following:

- **For Medicare Plus Blue:** Click on *Blue Cross* and then click on *Prior Authorization*. Scroll down and look under the "Authorization information for Medicare Plus Blue members" heading.
- **For BCN:** Click on *BCN* and then click on *Prior Authorization & Plan Notification*. Scroll down and look under the "Authorization criteria and preview questionnaires for select services" heading.

Authorization criteria and medical policies

The **Authorization criteria and preview questionnaires** document explains how to access the pertinent authorization criteria and medical policies.



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

Changes coming for select weight loss drugs for some commercial members

Blue Cross Blue Shield of Michigan and Blue Care Network are changing how we approach coverage of glucagon-like peptide-1 receptor agonist, known as GLP-1, drugs indicated for weight loss for our fully insured large group commercial members. These drugs include:

- Saxenda® (liraglutide)
- Wegovy® (semaglutide)
- Zepbound® (tirzepatide)

Here's what will change:

- **Aug. 1, 2024** – Prior authorizations for these drugs will end at midnight on July 31. A new prior authorization request will be required, and new prior authorization criteria will be applied for these members for dates of service from Aug. 1 through Dec. 31, 2024. Some members will require a new prescription to align with the new prior authorization criteria if the original prescriber didn't have an established relationship with the member or hasn't seen the member in person. For members with a plan renewal date other than Jan. 1, the new prior authorization will end prior to the renewal date.
- **Jan. 1, 2025** – Coverage for GLP-1 weight loss drugs for fully-insured large group commercial members will end starting Jan. 1, 2025. For group members with a plan renewal date other than Jan. 1, the coverage will end on the renewal date.

We're notifying the members affected by these changes and their prescribers.

We're changing prior authorization criteria

For dates of service from Aug. 1 through Dec. 31, 2024, Saxenda, Wegovy and Zepbound will have new prior authorization criteria for fully insured large group commercial members.

All current authorizations for these medications for these members will expire on July 31, 2024.

The following new criteria will apply for fully insured large group commercial members:

- The member must be 18 years or older and have a body mass index of 35 or higher.
- The medication must be prescribed by a health care provider who has an established relationship with the member and has seen the member in person.
- The prescriber must document the member's current baseline weight (within 30 days).
- The prescriber must document the member's active participation in a lifestyle modification program (working with a coach, tracking food and exercising) for a minimum duration of six months before the prior authorization request. The prescriber will no longer be able to attest to a member's participation. The prescriber must submit documentation, or the request will be denied.
- The member must enroll and participate in the **Teladoc® Health program for weight management**. This is a program at no cost to eligible members that offers easy-to-use tools and support. The prescriber must submit documentation of the member's active participation, or the request will be denied.

In addition to the requirements above, Saxenda, Wegovy, and Zepbound:

- Can't be used in combination with other weight loss products or other products that contain GLP-1 agonists
- Aren't covered for members with Type 2 diabetes

Please see Changes coming for select weight loss drugs continued on Page 38

Changes coming for select weight loss drugs,

continued from Page 37

For more information on how to submit a prior authorization electronically:

1. Go to **ereferrals.bcbsm.com**.
2. Select *Blue Cross* for PPO members or *BCN* for HMO members.
3. Click *Pharmacy Benefit Drugs* in the left navigation.
4. See the section, "How to submit an electronic prior authorization, or ePA, request."

What you need to do

If you have Blue Cross or BCN commercial members with a current prior authorization for Saxenda, Wegovy or Zepbound, ask the member if he or she is affected by this change. The member will know they're affected if they receive a letter from Blue Cross. The member can also check their Blue Cross member app or call the customer service number on their ID card.

If the member is affected, you'll need to submit a new prior authorization request following the new requirements for dates of service beginning Aug. 1, 2024. Based on the new requirements, the member may require a new prescription. If the new coverage requirements are not met, or the documentation noted above is not included in the prior authorization request, these Blue Cross and BCN members will no longer qualify for coverage.

We're changing coverage

Beginning Jan. 1, 2025, Blue Cross and BCN will no longer cover any GLP-1 drug for weight loss for fully insured large group commercial members. For group members with a plan renewal date other than Jan. 1, this change will go into effect on the renewal date.

This applies to all GLP-1 weight loss drugs, including Saxenda, Wegovy and Zepbound.

If you keep a member who is affected by this change on a GLP-1 drug for weight loss, that member will be responsible for the full cost of the drug.

We'll update our drug criteria documents

The following documents will be updated to reflect these changes as they occur:

- **Blue Cross PPO and BCN HMO prior authorization and step therapy coverage criteria**
- **Blue Cross PPO and BCN HMO prior authorization and step therapy coverage criteria for the Preferred Drug List**

Why Blue Cross and BCN are making these changes

We're making these changes in part because research has shown that a person's chance of success in losing weight and maintaining that weight loss is greatly improved when medication is paired with lifestyle changes, including diet and exercise.[1,2] This is why we're requiring that members on Saxenda, Wegovy or Zepbound participate in the weight management program through Teladoc Health.

In addition, prescription medications need to be effective as well as safe. Data published by the Blue Cross Blue Shield Association in May 2024 shows that most patients aren't staying on weight loss GLP-1 drugs long enough to see a benefit.[3] Due to the high cost of these drugs and supply considerations, we want to ensure they are used for the most appropriate patients who can achieve clinical benefit. Additional research is needed to understand whether GLP-1 interventions lead to lower medical costs in the long term.

Questions?

If you have questions, call the Pharmacy Services Clinical Help Desk at 1-800-437-3803.

[1]Jensen, S. B., Blond, M. B., Sandsdal, R. M., Olsen, L. M., Juhl, C. R., Lundgren, J. R., Janus, C., Stallknecht, B. M., Holst, J. J., Madsbad, S., & Torekov, S. S. (2024). **Healthy weight loss maintenance with exercise, GLP-1 receptor agonist, or both combined followed by one year without treatment: A post-treatment analysis of a randomised placebo-controlled trial**. *eClinicalMedicine, 69*, 102475. https://doi.org/10.1016/j.eclinm.2024.102475

[2]Dalle Grave, R. (2024). **The benefit of healthy lifestyle in the era of new medications to treat obesity**. *Diabetes, Metabolic Syndrome and Obesity, 17*, 227-230. https://doi.org/10.2147/dmso.s447582

[3]Blue Cross Blue Shield Association, Blue Health Intelligence Issue Brief (May 2024). **Real-World Trends in GLP-1 Treatment Persistence and Prescribing for Weight Management**. Retrieved from https://www.bcbs.com/sites/default/files/BHI_Issue_Brief_GLP1_Trends.pdf

Index

BCN Provider *News*

Feedback

W012705

INDEX: July-August 2024

BCN Advantage

Behavioral Health

Billing Bulletin

Network Operations

Patient Care/Quality

Pharmacy News

Referral Roundup