Blue Cross Blue Shield Blue Care Network of Michigan

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

COVID-19 utilization management changes

For Blue Cross' PPO (commercial), Medicare Plus Blue℠ PPO, BCN HMO℠ (commercial) and BCN Advantage℠ members

Revised Dec. 8, 2020

In this document

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

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

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

Earlier COVID-19-related messages on the topics below are still available on our coronavirus webpage. You can access that page through Provider Secured Services and on our public website at bcbsm.com/coronavirus (click *For Providers*).

Other changes temporarily put in place for the public health crisis can be found in the Temporary changes due to the COVID-19 pandemic document.

Acute care and post-acute care admissions

Clinical review requirements suspended until further notice for certain hospitals at higher inpatient bed occupancy

Initially published Nov. 25, 2020, as a Provider Alert.

Due to the recent surge in COVID-19 cases, Blue Cross Blue Shield of Michigan and Blue Care Network are temporarily suspending clinical review requirements for all non-elective medical cases for those hospitals most impacted by the pandemic.

Effective Nov. 25, 2020, and until further notice, the following changes apply to Michigan hospitals with a bed occupancy of 85% or higher[1]. These changes apply to all lines of business, including Blue Cross commercial, Blue Care Network commercial, Medicare Plus Blue and BCN Advantage:

- Clinical review requirements for all non-elective medical cases will be suspended in hospitals with inpatient bed occupancy at 85% or higher.

  [1]Blue Cross and BCN are evaluating hospital occupancy each Wednesday based on the previous week's data from the Michigan Department of Health & Human Services. This information can be found on the Statewide Available PPE and Bed Tracking webpage*** on the Michigan.gov website (see the Patient Census chart at the bottom). Non-elective medical cases will auto-approve beginning on the Monday following Blue Cross and BCN's evaluation. Once a hospital falls below the 85% bed occupancy rate for three consecutive weeks, non-elective medical cases will no longer auto-approve. Please see the *Temporary suspension of clinical review requirements* document for hospitals who have the clinical review requirements suspended each week. This document can be found within Provider Secured Services by clicking *Coronavirus (COVID-19)*. It is posted under the *Utilization management* section.

- Admissions to skilled nursing facilities from the hospitals that qualify for accommodations based on bed occupancy will auto-approve the first three days.

- Long-term acute care hospital and inpatient rehabilitation facility admissions from the hospitals who qualify for accommodations based on bed occupancy will receive

expedited processing with most decisions made within two hours of the request for discharge during normal business hours. Clinical review is still required.

Notes

- Non-elective admissions with suspended clinical review may be subject to a future audit.
- Hospitals and facilities that qualify for accommodations based on bed occupancy must still submit a plan notification, so an authorization is in our system when we receive the claim. A plan notification is a request for authorization submitted through e-referral for which no clinical documentation is required.
- Hospitals are encouraged to submit plan notifications through the e-referral system.
- Skilled nursing facilities that receive an admission from a hospital that qualifies for accommodations based on bed occupancy are not required to submit clinical documentation until the continued stay review, starting on the fourth day of stay.
- These changes do not apply to elective procedures or outpatient services. All other prior authorization requirements continue.
- These temporary changes do not apply to FlexLink® groups for which a third-party administrator makes authorization determinations. Facilities should check the back of the member's ID card to determine whether a third-party administrator needs to be contacted prior to an admission.

Clinical review requirements return July 1

Initially published June 30, 2020, as a Provider Alert

Some of this information is updated per the Provider Alert published Nov. 25, 2020.

Effective July 1, 2020, several temporary changes put in place during the COVID-19 pandemic have now ended.

Clinical review is again required for the services listed below. Effective July 1, 2020, you must submit clinical documentation when requested along with your authorization requests following the standard processes used prior to the pandemic for:

- Acute care admissions with COVID-19-related diagnoses (submit through the e-referral system)
- CT scans of the chest to rule out pneumonia diagnosis associated with COVID-19 for procedure codes *71250, *71260 and *71270 (submit to AIM Specialty Health®)
- The first three days of admission to a skilled nursing facility for members transferred from acute care (submit to Blue Cross or BCN for commercial members through the

e-referral system or by fax and to naviHealth for Medicare Plus Blue and BCN Advantage members)

Turnaround time on post-acute care determinations

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

naviHealth will make a same-day determination on all Medicare Advantage post-acute care requests received by 4 p.m. that day. This applies to admissions to skilled nursing facilities, long-term acute care hospitals and inpatient rehabilitation settings. In addition, for certain admissions to SNFs, naviHealth will implement an expedited review process.

Due to increased workloads, naviHealth is no longer able to make a determination on these requests within two hours.

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

Elective and non-urgent services

Blue Cross and BCN extend time to complete cardiac and pulmonary rehabilitation visits during COVID-19 emergency

Published Oct. 19, 2020, as a web-DENIS message

Blue Cross and BCN have extended the time to complete cardiac and pulmonary rehabilitation visits from 90 to 270 days* retroactive to March 1, 2020. The benefit period starts on the date of the first treatment or qualifying event depending on member coverage. The extended benefit period will continue until further notice.

This applies to Blue Cross PPO (commercial), BCN HMO (commercial) and BCN Advantage members (see chart below for details).

Medicare Plus Blue members do not have a limit on cardiac rehab; pulmonary rehab for Medicare Plus Blue is automatically extended when using the KX modifier.

The table below shows the differences per line of business but please consult web-DENIS for specific patient benefits. For background information, policy statements and summaries regarding these services, please see the Cardiac Rehabilitation and Pulmonary Rehabilitation medical policies found in the Medical Policy Router or log in to Provider Secured Services, click *BCN Provider Publications and Resources* and then click the *Medical Policy Manual* link.

	Blue Cross PPO	Medicare Plus Blue PPO	BCN HMO	BCN Advantage
Cardiac rehab (CPT codes *93797, *93798, revenue code 0943)	36 visits/year**	No limit	Visit limit varies based on the member's benefit. Authorization is required for all new cases. Must complete the cardiac rehabilitation questionnaire for BCN HMO members in e-referral.	No limits but authorization is required for new cases. Must complete the cardiac rehabilitation questionnaire for BCN Advantage members in e-referral.
Pulmonary rehab (HCPCS code G0237, G0238, G0239, G0302, G0303, G0304, G0424, S9473)	36 visits/year	36 visits per year without modifier; limit automatically extended when using KX modifier.	Visit limit varies based on the member's benefit. Authorization is required for all new cases. Must complete the pulmonary rehabilitation questionnaire in e-referral.	No limit but authorization is required for new cases. Must complete the pulmonary rehabilitation questionnaire in e-referral.

Duration of global referrals for BCN HMO members

Published Aug. 5, 2020, as a web-DENIS message

Blue Care Network is implementing another utilization management change aimed at supporting our providers during the COVID-19 emergency.

Here's what's changing for global referrals submitted for BCN HMO (commercial) members on or after March 13, 2020:

- For referrals with end dates in 2020, the end date will automatically be extended to Dec. 31, 2020.
- For referrals with end dates after Dec. 31, 2020, the end date specified in the e-referral system will apply.

This applies to global referrals submitted by both in-state and out-of-state providers. This doesn't apply to BCN Advantage, Medicare Plus Blue PPO or Blue Cross' PPO members, because global referrals are not required for those members.

Duration of authorization approvals

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

Any elective and non-urgent outpatient service authorization request approved on or after the dates listed below will be valid through Dec. 31, 2020:

- Blue Cross / BCN Utilization Management: March 13, 2020
- AIM Specialty Health: April 6, 2020
- eviCore healthcare: March 26, 2020
- TurningPoint Healthcare Solutions, LLC: June 1, 2020

Exception: For authorizations approved with an end date that goes beyond Dec. 31, 2020, the end date identified in the authorization letter will be honored.

This applies to authorizations approved for both in-state and out-of-state providers.

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

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

Initially published April 17, 2020, as part of a web-DENIS message
Published Oct 1, 2020, as an updated web-DENIS message

Effective Aug. 28, 2020, we're extending the benefit period from 180 to 270 days for completing physical, occupational and speech therapy (and physical medicine services by chiropractors). This applies to BCN HMO℠ members whose plans normally have a 60-consecutive-day benefit.

Note: In an April 17 web-DENIS message, we announced the initial extension of the benefit period from 60 to 180 days.

What actions to take to get the 270-day benefit period:

- For any members with therapy authorizations that began on or after March 26 but before Aug. 28 who need an extension beyond 180 days, providers can contact eviCore healthcare for an extension to 270 days. Providers can request an extension through the eviCore provider portal or by calling 1-855-774-1317.
- If the treatment extends beyond the member's benefit year, the provider must contact eviCore through their provider portal or by calling 1-855-774-1317, to request authorization of services for the new benefit year. The benefit will reset to 270-consecutive days in the new benefit year as long as the extension is still in effect and the member continues to have BCN coverage with the 60-consecutive-day therapy benefit.

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

This is different from — and in addition to — the extension of the length of time authorizations are valid, which we communicated in a May 29, 2020, web-DENIS message. That extension is scheduled to conclude Dec. 31.

Additional information

This change:

- Doesn't affect quantity limits, which still apply
- Is temporary, for the duration of the COVID-19 emergency, and is subject to revision upon further notice

All therapies must be medically necessary and must be authorized.

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

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

- You can contact us at a later date to update the dates of service once the services are rescheduled.
- If you've already gone through the clinical review process, we recommend keeping the authorization active and on file to prevent unnecessary delays in the future.

Laboratory testing

Laboratory network restrictions are lifted

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

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

Pharmacy

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

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

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

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

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

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

- CAR-T therapies (Kymriah® and Yescarta®)
- Diclegis®
- Gene therapy (Luxturna® and Zolgensma®)
- Hepatitis C treatment drugs
- Xiaflex®
- Xifaxin®

In addition, Blue Cross' PPO and BCN HMO members can refill their prescriptions early. We're taking this extra precaution so members will have enough medication to stay healthy.

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

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

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

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

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

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

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

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

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

**Some Blue Cross national contracts (NASCO) have different cardiac rehabilitation visit maximums and day limits for completion. This extension does not override these group-specific benefits. Please consult web-DENIS for specific member benefits.

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