COVID-19 utilization management changes
For Blue Cross’ PPO (commercial), Medicare Plus BlueSM PPO, BCN HMOSM (commercial) and BCN AdvantageSM members
April 8, 2020

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

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

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

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

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

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

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

- Blue Cross or BCN Utilization Management: March 13, 2020
- AIM Specialty Health®: April 6, 2020
- eviCore healthcare®: March 26, 2020

- For requests that are received through May 31, 2020: If approved, authorizations will be valid for 180 days. (This includes authorization requests submitted to TurningPoint Healthcare Solutions on or after May 1, 2020, for musculoskeletal surgical and other related procedures with dates of service on or after June 1, 2020.)

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

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

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

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**What’s changed**

Effective April 3 through May 31, 2020:

- Michigan acute care hospitals: Clinical review requirements at all acute care hospitals for all diagnoses are suspended. This applies to all medical admissions.

- Michigan post-acute care facilities: Clinical review requirements for the first three days of all skilled nursing facility admissions are suspended for members who are transferring from an acute care hospital.

**Exception:** These changes do not apply to Flexlink® groups for which a third-party administrator makes authorization determinations. Facilities should check the back of the member’s ID card to determine whether a third-party administrator needs to be contacted prior to an admission.
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April 8, 2020

How to submit these requests

- For acute care admissions, no clinical review is required.

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

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

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

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

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

- For post-acute care admissions:

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

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

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

How to submit, based on the line of business:

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

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

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

• You can contact us at a later date to update the dates of service once the services are rescheduled.

• If you’ve already gone through the clinical review process, we recommend keeping the authorization active and on file to prevent unnecessary delays in the future.

AIM Specialty Health implemented an updated guideline for advanced imaging

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

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

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

This applies to the following procedure codes:

• *71250

• *71260

• *71270

Laboratory network restrictions are lifted

For COVID-19 testing only, Blue Cross’ PPO, Medicare Plus Blue, BCN HMO and BCN Advantage will pay for testing from any laboratory provider in Michigan regardless of network status.
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Read about this and other COVID-19-related information on laboratory testing in the document COVID-19 patient testing recommendations.

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