2017 Blue Dot Changes to the *Blue Cross Complete Provider Manual* and related documents

The most recent changes are shown with a Blue Dot.

Change Description
The following updates are made to the *Blue Cross Complete Provider Manual* (January 2017): • Removed “Providers can request assistance through Provider Inquiry” in section one • Added Quest Diagnostics to “Preferred vendors for outpatient laboratory services, DME and diabetic supplies”
The following updates are made to the *Blue Cross Complete Provider Manual* (March 2017): • Added “Emergency Care” standards to “Access to appointments” • The chief medical officer at Blue Cross Complete will receive access and after hours corrective action plans from providers if a reply is not sent within 14 days • Updated steps in “Corrective action plan required for noncompliance”
The following updates are made to the *Blue Cross Complete Provider Manual* (May 2017): • Changed “Michigan Deparment of Human Services” to “Michigan Department of Health and Human Services” • Added “label on front of the card and the...” • Removed “Healthy Michigan Plan ID cards issued starting May 1, 2015, also show the Health Michgan Plan label on the front of the card” • Added “Plan” to “Healthy Michigan” • Removed “remaining sums” and added “services rendered” • Changed procedure code “99420” to “96160” • Added “attestation” to “physician signature and date” • Updated the most recent Michigan Department of Health and Human Services bulletin notice from “MSA 14-39” to “MSA 17-02” • Updated tobacco phone number to “1-800-480-7848”

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Change Description

The following updates are made to the *Blue Cross Complete Provider Manual* (June 2017):

- Removed “Providers can request assistance through Provider Inquiry” in section one
- Added Quest Diagnostics to “Preferred vendors for outpatient laboratory services, DME and diabetic supplies”

The following updates are made to the *Blue Cross Complete Provider Manual* (July 2017):

- **Section 2 - Systems of Managed Care (p. 15)**: Added *credentialing - Healthcare professional and provider rights* notice
- **Section 5 - Standards and Ratings (p. 28)**: Added M*onitoring timeliness of appointment* notice
- **Section 10 - Utilization Management (p. 54)**: Added “a Peer to Peer request will be accepted up to three calendar days from the date of original denial”
- **Section 13 - Claims**
- **Time limit for filing claims - Resubmissions (p. 70):**
  - Removed “latest remittance advice date or other activity” and added “last date of service
- **General guidelines for filing claims (p. 70)**
  - Added “Electronic Data Interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. It has also been proven to reduce claim re-work (adjustments). Therefore, it is preferred that all claims be submitted electronically”
  - Added “The National Drug Code (NDC), Unit of Measure and Units supplied are required for all drugs as indicated by MDHHS policies.
- **Claims Paper claims that do not meet HIPAA 5010 X12 format requirements (p. 76):**
  - Added Field # 25 - Federal Tax I.D. Number SSN/EIN information
  - Added Field #5 Federal Tax Number information (p. 77)
  - Added Field #43 - Revenue Description information (p. 77)

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Change Description

The follwong updates are made to the *Blue Cross Complete Provider Manual* (July 2017) continued:

- **Section 13 - Claims continued**
- **Guidelines for submitting corrected claims (p. 79):**
  - Added “Neither the Member ID nor the Billing Provider can be changed using a corrected claim. Providers must void the original cliam and submit a new claim with the correct Member ID and Billing Provider.
  - Added “On the CMS-1500, Field 22 must contain “7” followed by the original claim ID. On the UB-04, the original claim ID must show in Field 64 and the bill type in Field 4 must end in “7”.
  - Added “Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.”
  - Added “Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.” **(p. 80)**
  - Added Preferred vendors table **(p. 81)**

The follwong updates are made to the *Blue Cross Complete Provider Manual* (August 2017):

- **Section 8 - Member Benefits (p. 42)** - Changed CPT code for Health Risk Assessment from 99420 to 96160 and added “...and will reimburse an incentive payment of $15.”