



Blue Cross Blue Shield of Michigan 2007 Medicare Advantage Terms and Conditions

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Overview of BCBSM Medicare Advantage

Comprehensive Coverage for Members in a Single Plan

Blue Cross Blue Shield of Michigan's Medicare Advantage plans are comprehensive, private fee-for-service products for individual Michigan residents eligible for Medicare and for Medicare-eligible members of BCBSM groups offering Medicare Advantage coverage.

For these members, BCBSM Medicare Advantage products combine the benefits of Original Medicare (Part A and Part B) and supplemental coverage into a single health care plan.

Individual and Group Medicare Advantage Plan Options

- Medicare Plus BlueSM for individuals — Options A-D
- Group plans for group customers, such as the Michigan Public School Employees Retirement System and City of Detroit

Provider Access

BCBSM Medicare Advantage private fee-for-service plans allow members to obtain services from any provider in the United States who is eligible to be paid under Medicare rules and agrees to become a deemed provider.

BCBSM Medicare Advantage Members:

- Are not restricted to provider networks (see the two exceptions below)
- Do not need referrals to specialists or for other services
- Can obtain services from any provider in the United States who is eligible to be paid under Medicare rules and agrees to become a "deemed" provider

Network Exceptions:

- Pharmacies — there is a Part D pharmacy network
- Medicare Plus Blue members (those covered by an individual plan) have a DME/P&O and medical supply network in Michigan

¹ BCBSM 2007 Terms and Conditions are effective Jan. 1, 2007. Revisions made subsequent to this date will be explicitly noted.

Deemed Provider

BCBSM's Private Fee-for-Service Model

BCBSM's Medicare Advantage private fee-for-service plans use the Centers for Medicare and Medicaid Services deemed provider concept, rather than direct contracts (with some exceptions).

What Makes a Provider a "Deemed Provider"

- The provider knows before providing services that the patient is a BCBSM member with Medicare Advantage private fee-for-service coverage.
- The provider has reasonable access to BCBSM Medicare Advantage's terms and conditions.
- The provider subsequently provides services to the patient.

Once the provider meets these conditions and renders service, he or she is considered a deemed provider for that member for that episode of care. A decision to treat a specific member is ad hoc and does not require the provider to treat other Medicare Advantage plan members.

A provider can confirm an individual is a BCBSM Medicare Advantage member by viewing his or her ID card or by obtaining notice of enrollment from one of the following:

- The Centers for Medicare & Medicaid Services
- A Medicare intermediary
- A Medicare carrier
- BCBSM

A provider has reasonable access to the plan's terms and conditions of participation if the plan makes accessible its terms and conditions of payment through one or more of the following:

- A plan Web site
- Postal service
- Electronic mail
- Fax
- Telephone

It is the provider's responsibility to visit bcbsm.com/ma or call BCBSM Provider Services to obtain our conditions of participation.

Example: A member walks into a physician's office for the first time, advises the physician that he or she has BCBSM Medicare Advantage private fee-for-service coverage and presents his or her member ID card. Since the provider had the opportunity to call the plan phone number on the member's card, the provider is considered deemed as soon as he or she provides services, even though the provider did not actually check the terms and conditions of payment.

Additional Deemed Provider Requirements:

Deemed Providers Must:

- Be licensed or certified by the state and be acting within the scope of that license or certification, if applicable.
- Not be excluded by Medicare or must not have opted out of Medicare.
- Have a valid Medicare billing number.
- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members, including inspections and audits.
- Not discriminate against BCBSM Medicare Advantage members based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Collect the total reimbursement amount less member cost-sharing from the Medicare Advantage plan.
- Agree to collect from members only the cost-sharing amounts listed in the Summary of Benefits and must not otherwise charge or bill the member.
- Return to the member the total reimbursement amount less member cost-sharing.
- Not balance bill the member.
- Be certified to treat Medicare beneficiaries (if an institutional provider).
- Follow the standards for confidentiality and patient privacy rights outlined in HIPAA regulations.
- Agree to comply with all BCBSM Medicare Advantage appeal and grievance procedures.
- Agree that in no event, including but not limited to nonpayment by BCBSM, Medicare Advantage insolvency or breach of the Agreement, shall you or your assignees and/or subcontractors bill, charge, collect or deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against members of BCBSM Medicare Advantage or persons other than BCBSM Medicare Advantage acting on their behalf, for covered services provided to members by you. This provision shall not prohibit collection of payments for any noncovered services or member cost-share amounts set for the above. You further agree that: (1) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between you and a member or persons acting on their behalf and (2) this provision shall apply to all of your employees, agents, trustees, assignees and subcontractors, and you shall obtain from such persons specific agreement to this provision.

What if the Deemed Provider Conditions Cannot Be Met?

BCBSM will provide payment for circumstances that do not offer the opportunity for the deemed provider conditions to be met (e.g., emergency ambulance services where the member and the provider do not typically discuss coverage or ID card information).

- For these services, the provider may collect only the applicable deductible, copayment or coinsurance amount from the member.
- Providers may not otherwise charge, bill or balance bill the member.
- The provider must follow BCBSM's claims submission procedures.
- BCBSM will reimburse the provider the amount he or she would have received under Original Medicare, net of member cost-sharing.
- When appropriate, BCBSM will pay the limiting charge plus the amount the provider would have received under Original Medicare, net of member cost-sharing.

- If a provider mistakenly collects more from a member than the designated copayment or coinsurance amount, the provider must:
 - Return to the member the total reimbursement amount less member cost-sharing.
 - Collect the total reimbursement amount less member cost-sharing from BCBSM.

What if I do not want to accept BCBSM's terms and conditions?

If a provider knows the member has BCBSM Medicare Advantage coverage and does NOT want to accept our plan's terms and conditions, he or she should not provide services to the member. Once services are rendered, the provider is considered deemed and will be paid accordingly.

BCBSM is required to monitor the amount collected by deemed and noncontracting providers to ensure the amount collected does not exceed the member's cost-sharing amount, unless the provider has opted out of Medicare. BCBSM must develop and document violations specified in instructions and forward documented cases to CMS.

What if I have "opted-out" of Medicare?

Providers of Part B services who opt-out of the Medicare program may establish, in writing, private contracts with BCBSM Medicare Advantage private fee-for-service members for all covered Part B services except those services provided for emergency and urgently needed services.

- Under these private contracts, the Medicare Advantage member is liable for payment and neither the opt-out provider nor the member may bill BCBSM.
- BCBSM will pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the member.
- BCBSM will not otherwise pay opt-out providers.

What if I have been excluded from payment under the Medicare program?

The Office of Inspector General has a limited exception that permits payment for emergency services provided by excluded providers under certain circumstances. See 42 CFR 1001.1901

[ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=9c2603191d5ffbc55fbb6660b9b71769&rgn=div8&view=text&node=42:4.0.2.8.2.4.224.2&idno=42](https://www.ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=9c2603191d5ffbc55fbb6660b9b71769&rgn=div8&view=text&node=42:4.0.2.8.2.4.224.2&idno=42)

Medicare Advantage Reimbursement Policies

General Methodology and Coverage Information

Payment for services provided to members with Medicare Advantage private fee-for-service coverage is based on Original Medicare reimbursement methodologies and Medicare Advantage payment rules. However, member liability for these services is not always consistent with Original Medicare. See Summary of Benefits documents for full information on member liability. Information about the reimbursement methodologies used by Medicare Advantage, including but not limited to the following, can be found at cms.hhs.gov/center/provider.asp:

- Fee-for-service
- Prospective payment systems
- Interim payment rates
- Bonus payments

BCBSM's Medicare Advantage plan follows all CMS general coverage guidelines, national coverage determinations and written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the plan.

Provider Types

In general, when a member obtains service from a provider, then for those services, that provider is classified into one of the following three mutually exclusive provider types:

Direct-Contracting Providers:

For Medicare Plus Blue members in Michigan, BCBSM has a network for DME/P&O medical supplies and Part B drugs that are subject to DME regional carrier jurisdiction.

- This network is administered by DMEnson Benefit Management and does not currently apply to group members with Medicare Advantage coverage.
- Network providers in Michigan rendering services to Medicare Plus Blue members are reimbursed according to the contracted amount determined by DMEnson Benefit Management.
- Per CMS regulations, Deemed-Contracting providers in Michigan who provide DME/P&O or medical supplies are reimbursed the same as Michigan network providers who contract with DMEnson. However, Medicare Plus Blue members have a 50 percent coinsurance for most DME/P&O and medical supplies provided by Deemed-Contracting providers. (Some exceptions apply).

BCBSM also has a pharmacy network for Medicare Plus Blue and group Medicare Advantage members.

Deemed-Contracting or "Deemed" Providers:

- Reimbursement for deemed providers is based on the Medicare-allowed amount for participating providers.
- However, providers who do not participate under Original Medicare may become deemed providers under BCBSM's Medicare Advantage product as long as all other provider conditions are met.

Noncontracting Providers:

- Reimbursement for noncontracting providers is provided only under circumstances where the deemed-contracting conditions cannot be met;

- BCBSM will reimburse the provider the amount he or she would receive under Original Medicare, net of member cost-sharing;
- When appropriate, BCBSM will pay the limiting charge plus the amount the provider would have received under Original Medicare, net of member cost-sharing.

BCBSM will not reimburse any provider for a service that is not covered under Original Medicare, unless such service is specifically listed as a covered service under the member's Medicare Advantage plan. Summary of Benefits charts can be referenced to determine covered services and member cost-sharing amounts.

Special Medicare Advantage Rules:

The MA Payment Guide provides the following unique payment information for Medicare Advantage plans:

Acute Care Hospitals With Teaching Programs

Operating Indirect Medical Education and Direct Graduate Medical Education for inpatients are paid by the fiscal intermediary on behalf of Medicare Advantage members. Hospitals must submit two bills:

- Bill the Medicare fiscal intermediary for operating IME and direct GME payments.
- Bill all other acute inpatient care charges to the local Blue plan.

Your DRG payment from the Blue plan will not include payment for IME and DGME.

Audit Process

BCBSM conducts audits in accordance with Medicare laws, rules and regulations. BCBSM will conduct other audits as needed including DRG validation audits, readmission audits, and audits at skilled nursing facilities.

Bad Debt

CMS policy states that Medicare Advantage plans are not required to pay their members' unpaid cost-sharing. BCBSM will not reimburse providers for bad debt incurred by BCBSM Medicare Advantage members.

Balance Billing

Private fee-for-service plans can choose in their terms and conditions whether or not to allow all providers to balance bill up to 15 percent. BCBSM's Medicare Advantage plans do not allow providers to balance bill.

Claims Processing Requirements

All private fee-for-service plans are required by law to process 95 percent of all error-free claims (known as clean claims) within 30 days of receipt by the plan.

Clinical Trials

Carriers and fiscal intermediaries will reimburse qualifying clinical trial claims on behalf of Medicare Advantage members. Providers need to submit bills to carriers and intermediaries using the proper modifiers and ICD-9 codes. Medicare covered services not affiliated with clinical trials must be billed to BCBSM to be reimbursed according to the appropriate methodology.

Critical Access Hospitals

Michigan critical access hospitals should send their interim rate letters to their provider consultants. All critical access hospitals outside of Michigan should contact the provider services area of their local Blue plan to determine where the interim rate letters should be sent.

Cost Settlement

Original Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted. After the hospital's fiscal year ends, the fiscal intermediary settles with providers for the difference between interim payments and actual reasonable costs. CMS policy does not require Medicare Advantage plans to agree to settle with providers. Thus, BCBSM will not pay providers and providers will not pay BCBSM for the difference between interim payments and actual reasonable costs.

Federally Qualified Health Centers

- BCBSM will pay federally qualified health centers 80 percent (of the lesser of the interim rate or the applicable urban or rural national limit) plus 20 percent of the actual charge, minus the member's cost-sharing amount.
- BCBSM will pay federally qualified health centers that do not have an interim rate letter 80 percent of the applicable urban or rural national limit plus 20 percent of the actual charge, minus the member's cost-sharing amount.
- Michigan federally qualified health centers should send their interim rate letters to their provider consultants.
- Federally qualified health centers outside of Michigan should contact the provider services area of their local Blue plan to determine where the interim rate letters should be sent.
- All federally qualified health centers must submit claims for flu and pneumococcal vaccine services using specific procedure codes to receive reimbursement. Payment for these services will be provided on a fee-for-service basis consistent with Original Medicare.

Home Health Agencies

Home health agencies do not have to submit the OASIS to the state.

Hospice Services

- BCBSM Medicare Advantage does not cover hospice services. Hospice care providers should send all claims for hospice services to their regional home health intermediary for processing and reimbursement.
- For services completely unrelated to the terminal condition for which hospice services are elected, send claims to the local Blue plan.

Interest Payment

In the event that BCBSM does not process a clean claim within the 30-day time frame, BCBSM will pay interest in accordance with federal guidelines. BCBSM must process all claims within 60 days of receipt.

Mass Immunizers

- BCBSM Medicare Advantage provides full coverage for influenza and pneumococcal polysaccharide vaccines with no copayment required.
- Providers and suppliers already enrolled in the Medicare program may use their existing Medicare provider number and use the roster billing process as long as they provide the flu vaccine or PPV to multiple members. BCBSM Medicare Advantage will accept roster billing using paper claims.
- Mass immunizers must meet Original Medicare requirements in order to use the roster billing method for BCBSM Medicare Advantage. Providers and suppliers who wish to roster bill for mass immunizations must contact the local Blue plan for patient roster forms.

Record Retention

As a CMS contractor, BCBSM must retain all records for 10 years. Providers have a seven-year statute of limitations to retain their records.

Rural Health Clinics

BCBSM will pay rural health clinics 80 percent (of the lower of the provider specific rate or the national per-visit payment limit) plus 20 percent of the total charge for covered services, minus the member's cost-sharing amount.

- BCBSM will pay rural health clinics that do not have an interim rate letter 80 percent of the applicable urban or rural national limit plus 20 percent of the actual charge, minus the member's cost-sharing amount.
- Rural health clinics owned by rural hospitals with fewer than 50 beds are not subject to the national per-visit payment limit.
- Michigan rural health clinics should send their interim rate letters to their provider consultants. All rural health clinics outside of Michigan should contact the provider services area of their local Blue plan to determine where the interim rate letters should be sent.
- All rural health clinics must submit claims for flu and pneumococcal vaccine services using specific procedure codes to receive reimbursement. BCBSM will pay for these services on a fee-for-service basis consistent with Original Medicare.

Summary of Benefits

- BCBSM provides a Summary of Benefits document to all members following enrollment. This document provides general benefit information for members by plan option. It also describes member cost-sharing requirements that can be used by the provider to collect payment at the time the service is provided rather than waiting for the claim to be processed and the member billed.
- Original Medicare benefit coverage rules apply, except where noted. BCBSM will not reimburse providers for services not covered under Original Medicare, unless such services are specifically listed as covered services under the member's Medicare Advantage plan.
 - For individual BCBSM Medicare Advantage members:
bcbsm.com/medicare/compare.shtml
 - For group BCBSM Medicare Advantage members:
[Michigan Public School Employee Retirement System \(PDF\)](#)
[City of Detroit \(PDF\)](#)

Member Cost-Sharing

Member cost-sharing amounts are the responsibility of the member. Providers should collect deductibles, copayments or coinsurance from the member at the time of service.

Balance Billing is Prohibited

Providers may collect only applicable copayment or coinsurance amounts from BCBSM Medicare Advantage members and may not otherwise charge or bill the member.

Refund Over-billed Members

If a provider mistakenly collects more than the designated cost-sharing amount, from a member, the provider must

- Return to the member the total reimbursement amount, less member cost-sharing.
- Collect the total reimbursement amount less member cost-sharing from BCBSM by billing the Medicare Advantage program.

Provider Monitoring Requirements

BCBSM is required to monitor the amount collected by all providers to ensure that the amount collected does not exceed the member's cost-sharing amount, unless the provider has opted out of Medicare. BCBSM must develop and document violations specified in instructions and forward documented cases to CMS.

BCBSM Medicare Advantage Eligibility Verification

How to Verify Eligibility:

- Each time your patient receives care, check with the member to see if there have been any changes in coverage.
- Ask to see the patient's **BCBSM Medicare Advantage ID Card** or acknowledgement letter at every encounter
- Verify eligibility and coverage
- Call 800-676-BLUE (2583)
- Michigan providers can verify eligibility and coverage online through **web-DENIS**

The BCBSM Medicare Advantage ID card indicates the member is enrolled in a BCBSM Medicare Advantage plan. Look for the following:

- **bcbsm.com/ma** – Use this URL to access our terms and conditions.
- The BCBSM logo
- The Michigan plan code 210 or 710
- The words “Medicare Advantage”
- “PFFS,” signifying this is a private fee-for-service plan
- The alpha prefix:
 - **XYA** for our individual Medicare Plus Blue plans
 - **MQA** for the Michigan Public School Employees Retirement System Medicare Advantage Plan

Member Notification Requirements

Noncovered Services

Both Medicare beneficiaries and providers have certain rights and protections related to financial liability under Medicare Advantage programs. These financial liability and appeal rights and protections are communicated through notices given to providers. If an item or service is not covered under Original Medicare or the member's Medicare Advantage plan; providers, physicians, practitioners and suppliers must inform the member before providing the service that it will not be covered. The notice can be oral or written but providers are encouraged to document the discussion.

Notification of Hospital Discharge Appeal Rights (CMS-4105-F)

cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage

Effective July 1, 2007, hospitals will use a revised version of the Important Message from Medicare, or IM, an existing statutorily required notice, to explain the member's discharge rights.

- Hospitals must issue the IM within two days of admission, and must obtain the signature of the BCBSM Medicare Advantage member or his or her representative.
- In cases where the IM is delivered more than two days before discharge, hospitals are required to give the BCBSM Medicare Advantage member a copy of the signed IM before discharge.
- For BCBSM Medicare Advantage members who request an appeal, the hospital or health plan (if applicable) will deliver a more detailed notice.
- Proof of the above actions must be available in accordance with CMS instructions.

Notice of Medicare Non-Coverage for Skilled Nursing, Home Health or CORF
bcbsm.com/ma/pdf/H2319_NotMedNonCov.pdf

A BCBSM Medicare Advantage provider must deliver, in advance, a Notice of Medicare Non-Coverage to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation services no later than two days before the termination of services.

- This form may not be modified other than those fields providing specific information to the member.
- If the facility is not located in Michigan, the provider should replace the Quality Improvement Organization information on the form with his or her state's QIO address and phone number.
- Proof of the above actions must be available in accordance with CMS instructions.
- Providers must send a copy of the Notice of Medicare Non-Coverage to:
Grievance and Appeals Department
BCBSM Medicare Advantage — Mail Code X509
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Detailed Explanation of Non-Coverage

If a provider receives a notice from the quality improvement organization that one of our Medicare Advantage members is appealing a termination decision about his or her SNF, HHA or CORF services, the provider must provide a notice of Detailed Explanation of Non-Coverage to the member, the QIO and BCBSM.

- For instructions on completing the Detailed Explanation of Non-Coverage form, go to cms.hhs.gov/MMCAG/Downloads/DENCIInstructions.pdf.
- To access the Detailed Explanation of Non-Coverage form, go to bcbsm.com/ma/pdf/H2319_DetExplanNonCov.pdf.

A copy of the notice must be faxed to BCBSM at 248-350-4448 or sent to the following address:

Grievance and Appeals Department
BCBSM Medicare Advantage — Mail Code X509
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

This notice must be provided no later than the close of business, typically 4:30 p.m. on the day that the QIO notifies the SNF, HHA or CORF that the member has requested an appeal, or the day before coverage ends, whichever is later.

Long-term care facilities and pharmacies should post or distribute notice of member's rights

CMS requires long-term care facilities and pharmacies to post or distribute notice of the member's right to contact their Medicare Advantage prescription drug plan to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist. Long-term care staff must provide this notice to the member, or his or her authorized representative, and the member's treating physician. A copy of the notice should also be included in the member's file at the long-term care facility.

Anticipated Cost-sharing

Hospitals are required to provide members with a notice of anticipated cost-sharing if the member's expected cost-sharing amount for the admission will be \$500 or greater.

Organization Determinations

Medicare Advantage Organization Determination

Per CMS, each Medicare Advantage organization must have a procedure for making timely organization determinations regarding the benefits a member is entitled to receive under an Medicare Advantage plan and the amount, if any, that the member is required to pay for a health service. The organization is required to have a standard procedure for making determinations as well as an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the member's life, health or ability to regain maximum function.

Any of the following can request an organization determination:

- The member (including his or her authorized representative)
- Any provider that furnishes, or intends to furnish, services to the member
- The legal representative of a deceased member's estate

Expedited determinations can be requested by the member (including his or her authorized representative) or a physician.

Circumstances for requesting an organization determination include the following:

- Payment is sought for temporarily out of the area renal dialysis services, emergency services, post-stabilization care or urgently needed care
- Payment is sought for any other health services furnished by a provider that the member believes:
 - Are covered under Medicare
 - Should have been furnished, arranged for, or reimbursed by the Medicare Advantage organization
- The Medicare Advantage organization refuses to provide or pay for services
- A service is discontinued or reduced.
- The Medicare Advantage organization fails to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member

Standard Time Frames and Notice Requirements

- The Medicare Advantage organization must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 days after the date the organization receives the request.
- The organization may extend the time frame by up to 14 calendar days under certain circumstances.

How to Make a Request

If you are requesting a quick decision outside of regular business hours; in addition to sending the fax, you must call 800-545-7100 and leave a message. TTY users should use the AT&T Relay Service at 800-855-2880 to leave a message. The service is available 24 hours a day.

Phone: 800-545-7100 (TTY/TDD: 800-579-0235) between 8:30 a.m. and 5:30 p.m. Eastern time, Monday through Friday

Fax: 248-350-4448

Write: Grievance and Appeals Department
BCBSM Medicare Advantage — Mail Code X509
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Part D Coverage Determination

The Medicare Part D Coverage Determination Request Form (Link) is used by providers to request considerations under Part D coverage, including but not limited to the following:

- Prior Authorizations
- Tier Exceptions
- Step Therapy
- Coverage Determinations
- Request for Expedited Review

This form must be completed by a prescribing physician, member or authorized representative. If no clinical documentation is received to support the request, the request will be denied. If an authorized representative completes the form, documentation of authorized status must be submitted with the Authorized Representative Form. bcbsm.com/pdf/medicare/phy_CMS_form.pdf

Proof of the above actions must be available in accordance with CMS instructions.

Where to send the form:

If you are requesting a quick decision outside of regular business hours, in addition to sending the fax, you must call 800-545-7100 and leave a message. TTY users should use the AT&T Relay Service at 800-855-2880 to leave a message. The service is available 24 hours a day.

Phone: 800-545-7100 (TTY/TDD: 800-579-0235) between 8:30 a.m. and 5:30 p.m. Eastern time, Monday through Friday

Fax: 248-350-4448

Write: Grievance and Appeals Department
BCBSM Medicare Advantage — Mail Code X509
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Billing Procedures

Step 1 - Follow all Medicare Billing Guidelines including use of your Medicare PIN

- Use standard Medicare claim formats
 - Electronic submitters: ANSI 837 - preferred
 - Billers submitting paper claims for professional services: CMS-1500
 - Billers submitting paper claims for services by facilities and institutions: CMS-1450 (UB-92)
- Apply Original Medicare coding rules
 - Use Medicare CPT codes and defined modifiers
 - Bill diagnosis codes to the highest level of specificity
 - Use CMS-approved HCPCS codes and CMS-approved modifiers

Step 2 - Apply BCBSM Medicare Advantage Unique Billing Requirements

All Providers:

Variable	ANSI 837 Format	CMS-1500 Claims Format	UB-92 or CMS-1450 Claims Format
Member Contract Number with Alpha Prefix	Field NM109 of 2010BA Loop	Field 1a	Field 60

Michigan providers should also include the following information:

Medicare Advantage special billing instructions			
Required data element	ANSI 837 version 4010A1	CMS – 1500 (12/90 or 08/05 version) Field	CMS-1450 (UB-92) Form locator
Insured's ID #	Loop 2010BA NM109 Subscriber Identification	1A – Member Number	60 – Member Number
Insured's Policy Group #	Loop 2000B SBR03 Group Number	11 – Group Number	62 – Group Number
Signature	Loop 2300 CLM06 Provider signature on file: must equal Y	31 – Signature of Physician or Supplier including degrees or credentials & Date (signature on file is not acceptable)	85 – Provider Representative Signature & Date (signature on file is not acceptable)
Source of Payment	Loop 2000B SBR09 Claim filing indicator MA – Facility MB – Professional	NA	50 – 1st position “C” for Medicare
Payer ID	Loop 2010BB NM109 Payer ID 00210 – Facility 00710 – Professional	NA	50 – 2nd thru 6th position “00210”

Step 3 - Submit Claims to Your Local Blue Plan

- Submit claims within 365 days from date of service. Otherwise, the service cannot be reimbursed.
- Providers will receive the **Remittance Advice from BCBSM** or their local BCBS plan.
- Providers will be reimbursed by BCBSM or their local BCBS plan.

Where to Send Paper Claims for BCBSM Medicare Advantage Members:

Use the standard CMS-1500 or CMS-1450 (UB-92) claim as appropriate. Send these claims as follows:

Provider	Send claims to
All Michigan providers	Medicare Advantage Blue Cross Blue Shield of Michigan P.O. Box 440 Southfield, MI 48037-0440
All Providers For HCPCS codes with DME regional carrier jurisdiction	Medicare Advantage DMEnson Benefit Management P.O. Box 81700 Rochester, MI 48308-1700
Non-Michigan providers (Follow Medicare billing guidelines.)	Your local Blue plan. Report the alpha prefix to ensure correct routing of the claim

Coordination of Benefits

- If a member has primary coverage with another health care carrier, submit a claim for payment to that carrier first. The amount payable by BCBSM Medicare Advantage will be governed by the amount paid by the primary plan.
- All Medicare Secondary Payer rules must be followed.
- BCBSM Medicare Advantage plans do not coordinate with Medigap.

Review the Medicare Secondary Payer rules: cms.hhs.gov/manuals/downloads/msp105c01.pdf

Durable Medical Equipment Providers, Prosthetic and Orthotic Suppliers, Medical Suppliers and Retail Pharmacies

Plan Options

Blue Cross Blue Shield of Michigan Medicare Advantage private fee-for-service products include plans for both individual and group coverage:

- The plan for individual members is called Medicare Plus Blue.
- The first group plan provides coverage for Medicare-eligible members of the Michigan Public School Employees Retirement System MPSERS.

Member Benefits

- Both plans include DME/P&O, medical supplies and Part B drugs that are covered under Original Medicare. BCBSM provides a Summary of Benefits document to all members following enrollment. This document provides general benefit information for members by Plan Option. It also describes member cost-sharing requirements that can be used by the provider to collect payment at the time the service is provided rather than waiting for the claim to be processed and the member billed.
- Original Medicare benefit coverage rules apply, except where noted. BCBSM will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the member's Medicare Advantage plan.
 - For individual BCBSM Medicare Advantage members:
bcbsm.com/medicare/compare.shtml
 - For group BCBSM Medicare Advantage members:
[Michigan Public School Employee Retirement System](#) (PDF)
[City of Detroit](#) (PDF)

CMS Jurisdiction List, Billing and Claims Submission

All providers should follow the CMS Jurisdiction List to determine where to send claims for services provided to BCBSM Medicare Advantage members. This list can be referenced at cms.hhs.gov/transmittals/downloads/R893CP.pdf.

- If a HCPCS code has DME regional carrier jurisdiction, then the claim should be submitted to DMEnson Benefit Management.
- If a HCPCS code has local carrier jurisdiction, then the claim should be submitted to your local Blue plan.
- If a HCPCS code has dual jurisdiction, then the claim should be submitted to either DMEnson Benefit Management or your local Blue plan based on the circumstances indicated on the CMS list.

Providers should submit claims as soon as possible after services are provided. Any services billed beyond 365 days from the date of service are not eligible for reimbursement.

Follow All Original Medicare Billing Guidelines and Be Sure to Include the Following on All Claims:

- Diagnosis code to the highest level of specificity
- Medicare Part B supplier number and federal tax identification number
- The member's Medicare Advantage number, including the alpha prefix, found on the member's ID card

For paper claims, the provider's name should be provided in Box 31 of the CMS-1500 claim form.

Submit paper claims to:

CMS Jurisdiction	Send claims to
All Providers: For HCPCS codes with DME regional carrier jurisdiction.	Medicare Advantage DMEnson Benefit Management P.O. Box 81700 Rochester, MI 48308-1700
MI Providers: For HCPCS codes with local carrier jurisdiction	Medicare Advantage Blue Cross Blue Shield of Michigan P.O. Box 440 Southfield, MI 48037-0440
Providers Outside of MI: For HCPCS codes with local carrier jurisdiction	Send the claim to your local Blue plan

Electronic Billing:

- For electronic billing instructions for HCPCS codes with DME regional carrier jurisdiction, contact DMEnson Benefit Management.
- For electronic billing instructions for HCPCS codes with Local Carrier jurisdiction, contact your EDI administrator.

Reimbursement for Services Provided to Medicare Plus Blue Members**Direct-contracting Providers:**

For Medicare Plus Blue members in Michigan, BCBSM has a network for those DME/P&O, medical supplies and Part B drugs that are subject to DME regional carrier jurisdiction.

- This network is administered by DMEnson Benefit Management and does not currently apply to group members with Medicare Advantage coverage.
- Network providers in Michigan rendering services to Medicare Plus Blue members are reimbursed according to the contracted amount determined by DMEnson Benefit Management. View the [DMEnson 2007 Fee Schedule](#).

Deemed-contracting or “deemed” providers:

- Per CMS regulations, Deemed-Contracting providers in Michigan who provide DME/P&O, medical supplies or Part B drugs to Medicare Plus Blue members are reimbursed the same as Michigan network providers who contract with DMEnson Benefit Management.
- However, Deemed-Contracting providers are considered “non-network” providers for Medicare Plus Blue members.
- Medicare Plus Blue members have a 50 percent coinsurance for most DME/P&O, medical supplies and Part B drugs provided by Deemed-Contracting providers. (See cost-sharing chart in this section.)

Reimbursement for Services Provided to Group Medicare Advantage Members

Group Medicare Advantage members (currently Michigan Public School Employees Retirement System and City of Detroit) must receive services from providers who deem to be contracted under their Medicare Advantage plan.

- Reimbursement for services with DME regional carrier jurisdiction is based on applicable DMEPOS amounts. The DME regional carrier fee schedule can be referenced at cms.hhs.gov/DMEPOSFeeSched/LSDDMEPOSFEE/list.asp#TopOfPage.
- Reimbursement for services with local carrier jurisdiction will be provided consistent with local carrier rates.

Member Cost-Sharing

Providers may collect only the appropriate deductible, copayment or coinsurance amount from the Medicare Advantage member and may not otherwise charge or bill the member. This amount varies by benefit category.

Category	Medicare Plus Blue Cost-Sharing		MPSERS Cost-Sharing
	Direct-Contracting Providers	Deemed-Contracting Providers	Deemed-Contracting Providers
Diabetic Supplies	No copayment	No copayment	No coinsurance
DME Supply Drugs	No copayment	No copayment	No coinsurance
Part B Drugs	No copayment	No copayment	10% coinsurance after the \$250.00 deductible has been met
DME	No copayment	50% Coinsurance	No coinsurance
P&O	No copayment	50% Coinsurance	No coinsurance
Supplies	No copayment	50% Coinsurance	No coinsurance

Refund Over-billed Members

If a provider mistakenly collects more from a member than the designated cost-sharing amount, the provider must:

- Return to the member the total reimbursement amount less member cost-sharing.
- Collect the total reimbursement amount less member cost-sharing from BCBSM by billing the Medicare Advantage program.

Provider Monitoring Requirements

BCBSM is required to monitor the amount collected by all providers to ensure that the amount collected does not exceed the member's cost-sharing amount, unless the provider has opted out of Medicare. BCBSM must develop and document violations specified in instructions and forward documented cases to CMS.

Medicare Part B Services vs. Part D Drugs

Learn more about the differences between Medicare Part B coverage and Medicare Part D prescription drug coverage: cms.hhs.gov/PrescriptionDrugCovContra/Downloads/BvsDCoverage_07.27.05.pdf

For questions about services with DME regional carrier jurisdiction, contact DMEension Benefit Management at 888-828-7858. For all other questions, please call your local Blue plan.

Provider Payment Questions

If providers have questions about the payment amount received from Blue Cross Blue Shield of Michigan for services provided to a Medicare Advantage member, they should contact their local plan.

Payment Other Than Anticipated

If the payment amount a provider receives (including the member cost-sharing) is less than the Medicare allowed amount for participating providers, the provider should contact the Blue plan that issued the payment to resolve the issue.

If the provider can demonstrate that he or she has not received proper payment, the Blue plan will pay the difference between what the provider originally received and what would have been paid to participating providers under Original Medicare. The provider must submit reasonable documentation to the plan showing the Original Medicare payment amount that applies to the service (e.g., a remittance advice from a Medicare carrier or fiscal intermediary).

DME/P&O and Medical Supplies

If providers have questions about reimbursement received for services identified by HCPCS code(s) with DME regional carrier jurisdiction, they should contact DMension Benefit Management at 888-828-7858.

Overpayment

The term “overpayment” represents incorrect payment received by a provider in excess of amounts due and payable under the Medicare statute and regulations.

BCBSM Medicare Advantage strives to ensure payment accuracy; however, mistakes do occur. If BCBSM Medicare Advantage pays more than the proper amount, providers are responsible for making voluntary refunds to BCBSM Medicare Advantage or members as soon as possible, without waiting for notification.

Providers who receive an incorrect payment for BCBSM Medicare Advantage claims should follow this process to refund money to a Blue plan:

- Include the check with all appropriate documentation and the remittance advice.
- Ensure the documentation identifies either the patients or claim numbers for which the money is being returned. This will allow us to credit the correct account.
- Staple the check and documentation together so they do not get separated when the mail is opened. Please do not use paper clips.
- If the check is from BCBSM, send the check to:

Blue Cross Blue Shield of Michigan — Mail Code H404
P.O. Box 366
Detroit, MI 48231-0366
- If the check is from another Blue plan, call that Blue plan’s provider service area to determine where the check should be sent.

Standard Appeal of a Denied Claim

A provider may file a standard appeal of a denied claim if he or she submits a **Waiver of Liability Statement to BCBSM** that says the provider will not bill the member regardless of the outcome of the appeal.

If providers have questions about the Medicare Advantage appeal process, please call 800-545-7100 or 800-579-0235 (TTY). Waiver of Liability Statements and Appeal letters should be sent to:

Grievance & Appeal Management Department
BCBSM Medicare Advantage — Mail Code X509
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Medical Care Management

BCBSM Medicare Advantage members have access to two excellent medical care management programs that promote quality health care services based on the member's health status.

The following programs are designed to assist BCBSM Medicare Advantage members:

- Preadmission Notification
- Care Management programs
 - Health Care Management
 - Disease Management
 - Case Management

Preadmission Notification

Preadmission notification applies to hospitals, hospitals with swing beds, skilled nursing facilities, rehabilitation facilities (free standing facilities and units within hospitals), long-term care hospitals, and mental health and substance abuse facilities.

To preserve continuity of care, we encourage the facility to notify BCBSM Medicare Advantage when admitting a BCBSM Medicare Advantage member. However, facilities do not need to request or receive prior authorization from BCBSM Medicare Advantage in order to admit members.

Facilities: Michigan providers with web-DENIS should use it for preadmission notification. Providers without web-DENIS and those outside of Michigan should call BCBSM Medicare Advantage at 800-572-3413 and provide the following information:

- Health care facility and type of facility
- Member's name, sex and BCBSM Medicare Advantage contract number
- Attending physician's name and phone number
- Estimated length of stay, admitting diagnosis, and planned procedures (if applicable)

Care Management Programs

Care management programs are available to BCBSM Medicare Advantage members. Providers both in and outside of Michigan are encouraged to refer patients to these programs when appropriate.

- Health care management assists patients with their health care concerns. BlueHealthConnection® provides members with health information and support to help them understand their health care issues, address their concerns, and work more closely with their providers. Eligible members have access to a wealth of health information and support including:
 - Online health information at bcbsm.com. Members can access BlueHealthConnection to view articles, tools, and quizzes that provide a wide variety of health information on thousands of topics.
 - Access to health coaches (usually registered nurses) 24 hours a day, seven days a week, to help members access health information and answer their health questions.
- Disease management supports members with chronic conditions like diabetes, heart disease or asthma. Members can work one-on-one with BlueHealthConnection coaches to understand their condition and ways to manage it.

Providers may refer BCBSM Medicare Advantage members for either health care management or disease management programs. Members can call us at 877-922-9355 on any day, at any time; or they can visit us on the Web at bcbsm.com.

- Case management assists in the day-to-day clinical management of patients with complex health issues. Once a patient is accepted into the program, patient care needs are coordinated through Care Guide (formerly known as Coordinated Care Solutions) with a treating physician.
- Care Guide will also visit face-to-face with members and their families who qualify for case management services.

Facilities may refer members for review by contacting Care Guide at 888-882-4369 or 800-418-1360 (TTY).