



Blue Cross Blue Shield of Michigan

2009 Terms and Conditions

January 1, 2009

Medicare Advantage Private Fee-for-Service Plans

Provider Services:

For help or information, please call
Provider Services or go to our Plan Web site
at bcbsm.com/ma.

Medicare Advantage: 866-309-1719

Blue Cross Blue Shield of Michigan
bcbsm.com/ma

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**BLUE CROSS BLUE SHIELD OF MICHIGAN
MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN
2009 TERMS AND CONDITIONS OF PAYMENT**

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1. Introduction

Medicare Plus Blue, Medicare Plus Blue Group and Blue Cross Blue Shield of Michigan Medicare Advantage, for the purposes of this document known as Medicare Plus Blue, are Medicare Advantage private fee-for-service plans offered by BCBSM. Medicare Plus Blue allows members to use any provider, such as a physician, dentist, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as 'Original Medicare') or eligible to be paid by Medicare Plus Blue for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Medicare Plus Blue member, you will be "deemed" to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and Medicare Plus Blue. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Medicare Plus Blue for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance coverage determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

2. When a provider is deemed to accept Medicare Plus Blue's terms and conditions of payment

A provider is considered by law to be *deemed* to have a contract with Medicare Plus Blue when all of the following three criteria are met:

- 1) The provider is aware, in advance of furnishing health care services, that the patient is a member of Medicare Plus Blue. All of our members receive a member ID card that includes the Medicare Plus Blue or Medicare Advantage logo that clearly identifies them as private fee-for-service members. The provider may further validate eligibility by calling 800-676-BLUE (2583). Michigan providers can also verify eligibility and coverage online through web-DENIS.
- 2) The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our Web site at bcbsm.com/ma/terms_and_conditions.shtml. The terms and conditions may also be obtained by calling Medicare Advantage Provider Inquiry at 866-309-1719. Dentists may call Dental Inquiry at 800-482-5141.
- 3) The provider furnishes covered services to a Medicare Plus Blue member.

If all of these conditions are met, the provider is deemed to have agreed to Medicare Plus Blue's terms and conditions of payment for that member specific to that visit. Note: You, the provider, can decide whether or not to accept Medicare Plus Blue's term and conditions of payment each time you see a Medicare Plus Blue member. A decision to treat one plan member does not obligate you to treat other Medicare Plus Blue members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Medicare Plus Blue member shows you an enrollment card identifying him/her as a member of Medicare Plus Blue and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

If you DO NOT wish to accept Medicare Plus Blue's terms and conditions of payment, then you should not furnish services to a Medicare Plus Blue member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

In order to be paid by BCBSM for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to Medicare Plus Blue, in accordance with HIPAA requirements.
- Have a National Provider Identifier in order to submit paper claims to Medicare Plus Blue.
- Furnish services to a Medicare Plus Blue member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Medicare Plus Blue to resolve any member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

BCBSM reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare (such as for direct graduate medical education) and minus any member required cost sharing, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to the [2009 Payment Methodology Grid](#).

Services covered under Medicare Plus Blue that are not covered under Original Medicare are reimbursed using the following fee schedule located at bcbsm.com/ma/pdf/fee_schedule.pdf.

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate Medicare Plus Blue co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill their local Blue plan for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our private fee-for-service plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amount(s).

To view a complete list of covered services and member cost sharing amounts under Medicare Plus Blue, go to bcbsm.com/ma/plans_sum.shtml. Health care providers may call us at 866-309-1719 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Medicare Plus Blue. Dentists may call BCBSM's Dental Inquiry Department at 800-482-5141. Be sure to have the member's ID number when you call.

Medicare Plus Blue follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Medicare Plus Blue, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Medicare Plus Blue does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Medicare Plus Blue members. For information on Medicare Plus Blue's prior notification policies, see section on "Prior notification rules" below.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including private fee-for-service plans. All cost sharing is the member's responsibility.

Prior notification rules

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, to assist us in better managing care for our members, we request that you notify us *prior* to the member receiving any of the following services:

Admissions to:

- hospitals
- hospitals with swing beds
- skilled nursing facilities
- rehabilitation facilities (free standing facilities and units within hospitals)
- long-term care hospitals
- mental health and substance abuse facilities

Medicare Plus Blue does not require the member or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at 800-572-3413 or go to bcbsm.com/ma/pre_admission.shtml.

Balance billing of members

A provider may collect only applicable plan cost sharing amounts from Medicare Plus Blue members and may not otherwise charge or bill members. Balance billing is prohibited by providers, including dentists, who furnish plan-covered services to Medicare Plus Blue members.

You must also provide a notice of anticipated cost sharing for the following additional services: 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.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by Medicare Plus Blue, insolvency of Medicare Plus Blue, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5. Filing a claim for payment

- You must submit a claim to your local Blue plan for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the *Medicare Claims Processing Manual* located at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.
- Prompt Payment BCBSM will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Medicare Plus Blue will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Medicare Plus Blue will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), 2006 American Dental Association, or the appropriate electronic filing format. Claims submitted for DMEPOS services that are subject to DME MAC jurisdiction should be billed to DMEnson Benefit Management on a CMS-1500 paper claim or, when available, the appropriate electronic format. The CMS jurisdiction list can be referenced at cms.hhs.gov/transmittals/downloads/R1605CP.pdf.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Dentists should bill using the appropriate CDT codes.
- Include the following on your claims:
 - National Provider Identifier.
 - The member's contract number with alpha prefix.
 - Provider's signature
 - Source of payment (electronic claims)
 - Payer ID (electronic claims)
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.
- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to Medicare Plus Blue at the time of billing.

- Where to submit a claim:
 - For electronic claim submission, send claims to your local Blue plan.
 - For paper claim submission, send claims to:

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 MAC jurisdiction	Medicare Advantage DMEnson Benefit Management P.O. Box 81700 Rochester, MI 48308-1700
Non-Michigan providers	Your local Blue plan. <i>Report the alpha prefix to ensure correct routing of the claim.</i>
Dentists	Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231-0049

- If you have problems submitting claims to us or have any billing questions, contact our technical billing resources at:

Electronic Claims	
Services with CMS local carrier jurisdiction and all dental services	<ul style="list-style-type: none"> • Michigan providers – Contact the Electronic Data Interchange Help Desk at 800-542-0945. An EDI user guide is also available at bcbsm.com/pdf/edi_userGuide.pdf. • Non-Michigan providers – Contact your local Blue plan
Paper Claims	
Services with CMS local carrier jurisdiction	<ul style="list-style-type: none"> • Michigan providers – Contact Provider Inquiry at 866-309-1719 • Non-Michigan providers – contact your local Blue plan
Services with CMS DME MAC jurisdiction	All providers – contact DMEnson Benefit Management at 888-828-7858
Dental services	<ul style="list-style-type: none"> • Contact the Dental Provider Inquiry Department at 800-482-5141

6. Maintaining medical records, dental records and allowing audits

Deemed providers shall maintain timely and accurate medical, dental, financial and administrative records related to services they render to Medicare Plus Blue members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide Medicare Plus Blue, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Medicare Plus Blue audits of risk adjustment data; Medicare Plus Blue determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Medicare Plus Blue will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

To encourage providers to submit member medical or dental records to Medicare Plus Blue when necessary, Medicare Plus Blue will reimburse the provider for the cost of copying and forwarding requested medical records and/or send plan staff on-site to obtain copies of the desired records.

7. Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Medicare Plus Blue. To obtain an advance coverage determination, call us at 866-309-1719, fax your request to 877-894-9531 or submit your request in writing 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

Medicare Plus Blue will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Medicare Plus Blue's justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, fax your request to 877-894-9531. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Medicare Plus Blue can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Medicare Plus Blue, submit your dispute in writing or by telephone:

Services with CMS local carrier jurisdiction		
Michigan Providers	Medicare Advantage Provider Inquiry P.O. Box 33842 Detroit, MI 48232-5842	866-309-1719
Non-Michigan Providers	Your local Blue plan	
Services with CMS DME MAC jurisdiction		
All providers	Medicare Advantage DMEnson Benefit Management P.O. Box 81700 Rochester, MI 48308-1700	888-828-7858
Dental services		
All dentists	Medicare Dental Appeals Mail Code R430 Blue Cross Blue Shield of Michigan 27000 W. 11 Mile Rd. Southfield, MI 48034-1234	800-482-5141

Additionally, please provide appropriate documentation to support your payment dispute e.g., remittance advice from a Medicare carrier would be considered such documentation. Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received by the plan. If we agree with your payment dispute, then we will pay you the additional amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing Medicare Plus Blue's dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with the independent review entity, First Coast Service Options, Inc., contracted by CMS. Provided below is a summary of the Independent Review program and instructions for filing a request for review of a payment dispute.

1. Decisions subject to the payment dispute process

Provider payment disputes include any decisions where there is a dispute that the payment amount made by the Medicare Advantage private fee-for-service plan to **deemed providers** is less than the payment amount that would have been paid under the Medicare Advantage private fee-for-service plan's terms and conditions or the amount paid to **non-contracted providers** is less than would have been paid under original Medicare (including balance billing).

2. Decisions not subject to the private fee-for-service provider payment dispute process

- Services denied for coverage issues such as Local Coverage Determinations (LCDs).
- National Coverage Determinations (NCDs).
- Medical necessity determinations are not subject to the private fee-for-service independent review process and should be sent to the appropriate Qualified Independent Contractor (QIC) for processing.
- Disputes between a contracted network private fee-for-service provider and the Medicare Advantage private fee-for-service plan are also not reviewed by the independent review entity or CMS.

3. Filing a request for independent review (payment dispute decision)

A request for an independent payment dispute decision must be submitted to First Coast Service Options in writing within 180 days of written notice from the Medicare Advantage private fee-for-service plan. The request must be in writing and should be made on a standard payment dispute decision form available at the First Coast Service Options's private fee-for-service Web site. All requests must be received within 180 days of a written decision by the Medicare Advantage private fee-for-service plan. A written request that is not made on the standard payment dispute decision form will be accepted if it contains all the required elements, as follows:

- Provider or supplier contact information including name and address.
- Pricing information, including NPI number (and CCN / OSCAR number for institutional providers), ZIP code where services were rendered, physician specialty, the name of the Medicare Advantage organization that made the redetermination including the specific private fee-for-service plan name, and whether the provider/supplier is deemed or non-contracted.
- Reason for dispute; a description of the specific issue.
- Copy of the provider's submitted claim with disputed portion identified.
- Copy of the private fee-for-service plan's original pricing determination.
- Copy of the private fee-for-service plan's redetermination (dispute) pricing decision.
- Copy of the relevant portion of terms and conditions or contract and any supporting documentation and correspondence that support your position that the plan's reimbursement is not correct (this may include interim rate letters where appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable.
- The name and signature of the party or the representative of the party.

4. Obtaining the Medicare Advantage organization documentation

Providers or suppliers that have exhausted the dispute resolution process of the private fee-for-service organization and wish to escalate must file requests for a payment dispute decision directly with the independent review entity. Once a party requests a payment dispute decision, the independent review entity may request documentation from the Medicare Advantage organization that processed the redetermination. When the Medicare Advantage organization receives the independent review entity's request for the case file, the Medicare Advantage organization must send the file within seven calendar days so that the independent review entity receives it on or before the eighth day. Private fee-for-service plans that do not respond timely to independent review entity requests will be considered out of compliance with their CMS contract and subject to compliance processes.

5. Time frame for making a payment dispute decision

The independent review entity will issue a decision within 60 days after receiving a provider payment dispute appeal unless granted an exception by the independent review entity. The independent review entity will:

- notify all parties of its payment dispute decision or
- notify all parties that it has dismissed the request for a payment dispute decision

6. Decision letters

The payment dispute decision letter will include the facts of the appeal, arguments made for and against additional reimbursement, the adjudicator's decision, and the adjudicator's rationale, and notification to the parties of their right to request a debrief.

7. Notification of parties

When the independent review entity renders a decision on a case it notifies all parties of its decision. The independent review entity considers the case closed when it notifies all parties of the decision. However, both parties have the right to request a debrief.

8. Compilation of decisions and lessons learned

The independent review entity will maintain a log of all decisions rendered and will work collaboratively with CMS to provide information back to private fee-for-service plans on the cases raised and the decisions rendered. Private fee-for-service plans will have the opportunity to learn from these experiences, and amend their practices accordingly.

To file a request for review of a payment dispute with the independent entity, you may contact the entity directly as follows:

1. **E-mail.** If the submission and associated documents do not contain any personally identifiable health information (or any personally identifiable health information has been redacted), the payment dispute decision request can be submitted to a dedicated e-mail box at IREPFFS@FCSO.com.

Otherwise, First Coast can receive payment dispute decision requests (including associated documents such as claims forms that may contain personally identifiable health information) via the following:

2. **Fax.** A fax number, 904-361-0551, has been established to receive electronic requests for payment dispute decisions.
3. **Mail.** Providers can also mail hard copy requests for payment dispute adjudication to the following address:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44017
Jacksonville, Florida 32231-4017

Review requests should be submitted using the [Provider Dispute Decision Request Form](#). This form is available at bcbsm.com/ma/pdf/PFFS_PDD_form.pdf.

Providers with questions regarding the adjudication process or individual disputes being reviewed by the independent review entity can contact First Coast Service Options at 904-791-6430. Providers will be able to leave messages and should expect a return call within 48 hours of receipt. Hard copy correspondence associated with a dispute request may be mailed to:

First Coast Service Options, Inc.
PFFS Payment Disputes
P.O. Box 44035
Jacksonville, Florida 32231-4035

9. Member and provider appeals and grievances

Medicare Plus Blue members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Medicare Plus Blue to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a **waiver of liability** (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Medicare Plus Blue Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call our Medicare Advantage Provider Inquiry at 866-309-1719, 8:30 a.m. to 5 p.m. for more information on our member appeals and grievance policies and procedures.

10. Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNC.pdf> and <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf>. In addition, the provider should send a copy of any NOMNC issued 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

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the timeframes specified by law.

For home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, to obtain the Detailed Explanation of Non-Coverage go to: http://www.cms.hhs.gov/BNI/09_MAEDNotices.asp#TopOfPage.

For hospitals, to obtain the Detailed Notice of Discharge go to: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp#TopOfPage.

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities should also send these detailed notices to BCBSM at 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

11. If you need additional information or have questions

If you have general questions about Medicare Plus Blue’s terms and conditions of payment, contact Medicare Advantage Provider Inquiry at 866-309-1719 (8:30 a.m. – 5 p.m.) or write to us at:

Medicare Advantage
 Provider Inquiry
 P.O. Box 33842
 Detroit, MI 48232-5842

DMEnson Benefit Management
 Call 888-828-7858 (8:30 a.m. – 5 p.m.) or write to:

Medicare Advantage
 DMEnson Benefit Management
 P.O. Box 81700
 Rochester, MI 48308-1700

- If you have questions about submitting claims, call us at:

Electronic Claims	
Services with CMS local carrier jurisdiction and all dental services	Michigan providers – Contact the EDI Help Desk at 800-542-0945 Non-Michigan providers – Contact your local Blue plan
Paper Claims	
Services with CMS local carrier jurisdiction	Michigan providers - Contact Provider Inquiry at 866-309-1719 Non-Michigan providers – Contact your local Blue plan
Services with CMS DME MAC jurisdiction	All providers – Contact DMEnson Benefit Management at 888-828-7858
Dental services	Contact the Dental Provider Inquiry Department at 800-482-5141

- If you have questions about plan payments, call us at:

Services with CMS local carrier jurisdiction	
Michigan Providers	Contact Provider Inquiry at 866-309-1719
Non-Michigan Providers	Your local Blue plan
Services with CMS DME MAC jurisdiction	
All providers	Contact DMEnson Benefit Management at 888-828-7858
Dental services	
All dental providers	Contact the Dental Provider Inquiry Department at 800-482-5141

Michigan Provider Inquiries:

Call 866-309-1719

Medicare Advantage
Provider Inquiry Services
P.O. Box 33842
Detroit, MI 48232-5842

Eligibility

Call 800-676-BLUE (2583)

DMEnson Benefit Management

Call 888-828-7858

P.O. Box 81700
Rochester, MI 48308-1700

What if I suspect fraud?

If you suspect fraud, please contact
Blue Cross Blue Shield of Michigan Anti-Fraud Hotline
at 888-650-8136 (24 hours a day/7 days a week).

bcbsm.com/ma



Blue Cross Blue Shield of Michigan contracts with the federal government and is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association