

Blue Cross Blue Shield of Michigan

Medicare Plus Blue **PPO Manual**

Effective January 1, 2010



Blue Cross Blue Shield of Michigan

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Medicare Plus Blue PPOSM Overview

Blue Cross Blue Shield of Michigan is an authorized Medicare Advantage Organization that contracts with Centers for Medicare & Medicaid Services to offer Medicare Plus Blue PPO and Part D prescription drug insurance plans in the senior market. BCBSM will offer Medicare Plus Blue PPO coverage to Medicare-eligible Michigan residents and Medicare-eligible members of BCBSM groups.

Medicare Plus Blue PPO plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows BCBSM to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit.

ID card

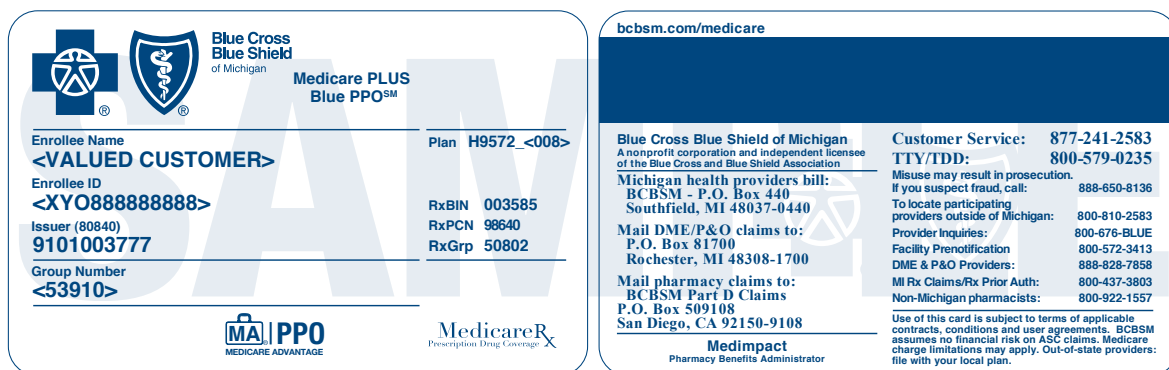
Overview

Our member identification cards contain basic information you will need when providing covered services to our members. The Medicare Plus Blue PPO ID card indicates the member is enrolled in a Medicare Plus Blue PPO plan.

All Blue Cross and Blue Shield Association (the national organization for all Blue plans) cards have a similar look and feel, which promotes nationwide ease of use. The cards include a magnetic stripe on the back which will eventually enable us to provide easier access to eligibility and benefit information.

Providers must include the three-character alpha prefix found on the member's ID card when submitting paper and electronic claims. The alpha prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm member coverage. It is critical for the electronic routing of specific transactions to the appropriate Blue Cross and/or Blue Shield plan.

Below is a sample of the members' ID card.



The "MA" in the suitcase indicates a member who is covered under the Medicare Advantage PPO network sharing program. As with other Medicare Plus Blue products, members should provide their ID cards when requesting services from you.

The front of the card may include:

- The subscriber name, also called the enrollee or member, who is the contract holder.
- The member ID, also called the contract number, which is made up of randomly chosen characters, either alpha-numeric or all numeric.
- The issuer ID number just below the member information. This number identifies which Blue plan issued the card (BCBSM or another plan.)
- A logo in the lower right corner of many cards, which identifies the member's prescription drug claims processor (for use by pharmacists).
- The Group number
- Our Web site address
- A magnetic stripe at the top
- Phone numbers
- An address showing where to send claims

Eligibility and Coverage

Each time your patient receives care, check with the member to see if there have been any coverage changes.

- Ask to see the patient's Medicare Plus Blue PPO ID card or acknowledgement letter at every encounter
- Verify eligibility and coverage
- Call 1-800-676-BLUE (2583)
- Michigan providers can verify eligibility and coverage online through web-DENIS

Web-DENIS

Web-DENIS is BCBSM's Web-based information system for providers. Web-DENIS is a great tool because it's:

- Complete – web-DENIS tells you what the patient is required to pay the provider for services, including the:
 - Total deductible amount
 - Remaining amount of the deductible that still needs to be paid
 - Copayments required for covered services
 - Out-of-pocket maximums or the highest dollar amount that the patient is required to pay
 - Remaining amount of the out-of-pocket maximum that still needs to be paid
- Fast – giving you the information you need quickly
 - Available 24 hours a day, seven days a week
 - User-friendly

If you need access to web-DENIS, we can help you get the information you need to use the system. Web-DENIS login and other information is available at bcbsm.com.

CAREN

If you don't have computer access, you can call CAREN to verify your patient's cost-sharing requirements. CAREN tells you the:

- Total amount of the deductible
- Remaining amount of the deductible that still needs to be paid
- Copayments required for covered services
- Out-of-pocket maximums or the highest dollar amount that the patient is required to pay
- Remaining amount of the out-of-pocket maximum that still needs to be paid

Call CAREN and follow the prompts for your specialty, or stay on the line to connect with a customer service representative during business hours. CAREN may be accessed by calling the Medicare Plus Blue provider call center at 1-866-309-1719.

Verifying eligibility and coverage for out of area members

To determine eligibility and cost-sharing amounts for out of area members, call the BlueCard line at 1-800-676-BLUE (2583) and provide the member's three-digit alpha prefix located on the ID card. You may also submit electronic eligibility requests for Blue Medicare Advantage PPO members.

Billing members

Collect deductible, copayments or co-insurance at time of service

Providers should collect the applicable cost-sharing from the member at the time of the service when possible. Cost-sharing refers to a flat-dollar copayment, a percentage coinsurance or a deductible. You can only collect the appropriate Medicare Plus Blue PPO cost-sharing amounts from the member. After collecting these amounts, bill your local Blue plan for covered services.

Balance billing is not allowed

You may only collect applicable cost-sharing from Medicare Plus Blue PPO members for covered services and may not otherwise charge or bill them.

Noncovered services

Sometimes you and your patient may decide that a service or treatment is the best course of care, even though it isn't covered by Medicare Plus Blue PPO.

If you believe that a service won't be covered, you need to tell the member before the service is performed. If the member acknowledges that it won't be covered by Medicare Plus Blue and agrees that he or she will be solely responsible for paying you, you may perform and bill the member for the noncovered service. This decision is between you and your patient, and the process is called notification of noncoverage.

We encourage you to give the notification and obtain acknowledgement in writing, although Centers for Medicare & Medicaid Services does not require documentation on a specific form for Medicare Advantage plans.

Refund over-billed members

If you collect more from a member than the applicable cost-sharing, you must refund the difference.

Coordination of benefits

If a member has primary coverage with another plan, submit a claim for payment to that plan first. The amount we will pay depends on the amount paid by the primary plan. We follow all Medicare secondary-payer laws*.

DME/P&O, medical suppliers and pharmacists

DMension Benefit Management

DMension Benefit Management processes claims for durable medical equipment, prosthetic and orthotic devices, medical supplies and Part B drugs subject to the DME regional carrier jurisdiction list for all Medicare Plus Blue PPO services. DMension Benefit Management reimburses providers based on the DMension fee schedule. If a service does not have a network fee available, Medicare's allowed-amount will be used. Out-of-network claims for Medicare Plus Blue PPO members will be reimbursed using the CMS fee schedule with a higher level of cost sharing applied.

The local Blue plan processes all DME and P&O claims with local carrier jurisdiction. Reimbursement for services with local carrier jurisdiction is consistent with original Medicare rates.

DME benefits, billing and CMS jurisdiction list

All Medicare Plus Blue plans include DME/P&O, medical supplies and Part B drugs that are covered under original Medicare. All providers should follow the CMS jurisdiction list to determine where to send claims for services provided to BCBSM Medicare Plus Blue PPO members. The CMS jurisdiction list can be referenced at www.cms.hhs.gov/transmittals/downloads/R1765CP.pdf*

Lab services

Medicare Advantage PPO Lab Network — A Medicare Advantage PPO laboratory network has been established with Quest Diagnostics and Joint Venture Hospital Laboratories to provide non-patient clinical and anatomic pathology lab services to Medicare Plus Blue PPO members. Non-patient services as defined by Medicare include specimens that are either couriered to a lab or are drawn at patient service centers, including those located on hospital campuses — *if no services are rendered by a physician or non-physician practitioner*. We encourage Medicare Advantage PPO providers to use the Medicare Advantage PPO lab network for all lab and pathology services to avoid out-of-pocket costs for members.

Locations of patient service centers are available on the JVHL (jvhl.org*) and Quest Diagnostics (questdiagnostics.com*) Web sites, or by calling their administrative offices at 1-800-445-4979 (JVHL) or 1-248-373-9120 (Quest). No cost sharing is applied when Medicare Plus Blue PPO members have lab services performed within the Medicare Advantage PPO lab network. Medicare Advantage PPO lab network, services are paid in full. For lab services performed at a Medicare Advantage network hospital that does not participate with JVHL, a \$25 copayment will apply. A 50 percent coinsurance is applied when members go outside of the network.

When you, or other qualified members of your office staff, obtain laboratory specimens in your office, Quest or JVHL can arrange for a courier to pick up the specimen. If you prefer, direct your patients to have their laboratory specimens collected at patient service centers of Quest or JVHL participating hospitals, which may be located on or off the hospital's campus. JVHL participating hospitals must bill JVHL for non-patient laboratory services rather than submitting claims directly to BCBSM.

Also covered are those pathology services associated with the lab services provided by JVHL participating hospitals or by Quest, and the test specimens registered by a JVHL participating hospital lab or by Quest Diagnostics and sent to an external reference laboratory. These tests must be billed to BCBSM by JVHL or Quest as part of the lab network program.

Practitioners may perform certain lab procedures in the office location without referring the patient or the specimen to a Medicare Advantage PPO lab network provider. These procedures are limited to those on BCBSM's **Medicare Advantage PPO Physician Office Lab List (POLL)***. The procedures on BCBSM's Medicare Advantage PPO POLL are those that BCBSM has determined to be appropriately provided in an office setting by practitioners when the test:

- Results are needed at the time of service to support making real time therapeutic decisions
- Can be performed economically and accurately
- Are medically necessary

Physician office lab list

The Medicare Advantage PPO Physician Office Lab List applies to members enrolled in Medicare Plus Blue PPO coverage. Payment will not be made to Medicare Advantage PPO practitioners and Medicare Advantage PPO practitioners may not bill members for laboratory services not found on this list, if performed in the practitioner's office (organized by CPT category).

36415**	82771	83721	86486	88240	89300
80101	82772**	83880	86490	88241	89321
80500	82274**	83986	86510	88304	89325
80502	82570	84061	86580	88305	G0027**
81000**	82679	84157	86618	88311	G0328**
81001**	82950	84443	86701	88312	Q0111
81002**	82951	84830	86703	88313	Q0112
81003**	82952	85013**	86999	88314	Q0113
81007**	82962**	85014**	87077	88329	Q0115
81015**	83001	85018**	87210**	89049	
81020	83002	85576	87449**	89055	
81025**	83013	85610**	87804**	89100	
81050	83014	85651	87807**	89105	
82010	83026**	86077	87808	89130	
82042	83036**	86078	87809	89132	
82044	83037	86079	87880**	89135	
82075	83518	86294	87899	89136	
82120**	83520	86308**	87900	89140	
82150	83655	86318**	87905	89141	
82270**	83718	86485	88125	89220	

** Denotes STAT Laboratory Codes. These procedures may be performed in the physician's office when performed to diagnose or treat a patient in the presence of a provider.

Codes effective Jan. 1, 2010

AIM Radiology Management Program

Radiology Management Program (RMP)

The Medicare Advantage PPO Radiology Management Program is a provider utilization management program for outpatient high-tech diagnostic radiology services.

American Imaging Management, Inc.

AIM administers the preauthorization requirements of the Medicare Advantage PPO Radiology Management Program for BCBSM. BCBSM is responsible for the administrative oversight and contract administration. Effective Feb. 8, 2010, providers can contact AIM to request preauthorization for dates of service on or after Feb. 22, 2010, by calling 1-800-728-8008 or via the internet at americanimaging.net*

Please Note: The program applies only to those Medicare Advantage PPO members residing within the State of Michigan and services rendered by Michigan providers. Non-Michigan residents, out-of-state providers, emergency room, observation room, inpatient services and secondary COB are not included in this program.

The Medicare Advantage PPO Radiology Management program includes the following requirements:

- Preauthorization of non-emergency outpatient CAT scans, MRIs, MRAs, nuclear cardiology procedures and PET scans
- Radiology privileging

Radiology Preauthorization

All Michigan, Medicare Advantage PPO physicians are required to contact AIM before ordering select high technology, select diagnostic imaging studies to be performed in office, outpatient hospital or freestanding centers for a Medicare Plus Blue PPO member. (Preauthorization is not required in the hospital inpatient or emergency room setting.) The RMP helps to ensure the most appropriate test is utilized for the diagnosis in question. It is a comprehensive approach to managing outpatient diagnostic imaging utilization, provides an interface for new technology procedures and helps to clarify radiological procedures as needed.

The ordering physician is to obtain preauthorization because he or she is more familiar with the member's clinical condition and indications for special imaging. However, the rendering physician should verify that the preauthorization has been obtained. Prior to any high-technology radiology exam/service being rendered, an approved preauthorization must be obtained in all locations including outpatient hospital services, in order for reimbursement to occur. Without preauthorization, claims may be denied with no member liability.

Members will receive preauthorization approval letters. Providers and members will also receive written notification of preauthorization denials with all applicable level one and level two appeal rights.

Providers who are not privileged, or those who are privileged but do not obtain preauthorization, may not be paid for services rendered and are prohibited by contract from billing the members for those services.

The following outpatient high-tech diagnostic radiologic procedures require preauthorization:

Procedure Codes						
70336	70545	72128	72194	73718	75556	78609
70450	70546	72129	72195	73719	75635	78811
70460	70547	72130	72196	73720	76390	78812
70470	70548	72131	72197	73721	77058	78813
70480	70549	72132	72198	73722	77059	78814
70481	70551	72133	73200	73723	77078	78815
70482	70552	72141	73201	73725	77079	78816
70486	70553	72142	73202	74150	77084	0067T
70487	71250	72146	73206	74160	78459	
70488	71260	72147	73218	74170	78466	
70490	71270	72148	73219	74175	78468	
70491	71275	72149	73220	74181	78469	
70492	71550	72156	73221	74182	78472	
70496	71551	72157	73222	74183	78473	
70498	71552	72158	73223	74185	78481	
70540	71555	72159	73700	75552	78483	
70542	72125	72191	73701	75553	78491	
70543	72126	72192	73702	75554	78492	
70544	72127	72193	73706	75555	78608	

Effective Jan. 1, 2010.

Radiology Privileging

The provider specialty privileging program allows non-radiology physicians to perform and interpret in the office those plain film and ultrasound exams for which they are appropriately trained. The programs are based on specialty training rather than a physician's individual credentials.

Providers who perform services in exempt Michigan counties are not subject to the privileging limitations. Those counties include the following:

PPO Radiology Management Program - Provider Specialty Privileging					
Exempt Counties:					
Alcona	Cass	Grand Traverse	Keweenaw	Missaukee	Ottawa
Alger	Charlevoix	Hillsdale	Lake	Montcalm	Presque Isle
Allegan	Cheboygan	Houghton	Leelanau	Montmorency	Roscommon
Alpena	Chippewa	Huron	Lenawee	Muskegon	Schoolcraft
Antrim	Clare	Ionia	Luce	Newaygo	St. Joseph
Baraga	Crawford	Iosco	Mackinac	Oceana	Sanilac
Barry	Delta	Iron	Manistee	Ogemaw	Van Buren
Benzie	Dickinson	Isabella	Marquette	Ontonagon	Wexford
Berrien	Emmet	Kalamazoo	Mason	Osceola	
Branch	Gladwin	Kalkaska	Mecosta	Oscoda	
Calhoun	Gogebic	Kent	Menominee	Otsego	

Physicians in the following primary specialties are not subject to privileging and may perform any in-office imaging for PPO members:

Anesthesiology – specialty code 05

Diagnostic radiology – specialty code 31

General surgery – specialty code 02

Neurosurgery – specialty code 14

Pediatrics – specialty code 35

Radiology – specialty code 30

Radiation oncology – specialty code 32

These specialties are approved to perform the in-office select imaging procedures (all codes are effective Jan. 1, 2010):

Cardiologists – specialty code 06

Procedure Codes				
Chest	Bone/joint studies	Nuclear medicine	Echocardiography	Noninvasive vascular diagnostic studies
71010	77080	78472	93303	93880
71020		78473	93304	93882
71021		78481	93306	93886
71022		78483	93307	93888
71023		78496	93308	93890
71030			93312	93892
71034			93313	93893
Other			93314	93922
76000			93315	93923
			93316	93924
			93317	93925
			93320	93926
			93321	93930
			93325	93931
			93350	93965
				93970
				93971
				93975
				93976
				93978
				93979
				93990

Chiropractors (Specialty codes 12 and 95)

Procedure codes	
Spine and pelvis	
72010	72090
72020	72100
72040	72110
72050	72114
72052	72120
72069	72170
72070	72200
72072	72202
72074	72220
72080	

Dermatology – specialty code 07

Procedure Codes	
Ultrasound	Noninvasive vascular diagnostic studies
76942	93970
	93971

Endocrinologists – specialty codes 85

Procedure Codes
76536
76942
78000
79005

ENT physicians – specialty codes 04 and 17

Procedure Codes		
Head and neck	Ultrasound	Bone/joint studies
70110	76510	77080
70130	76511	
70150	76512	
70160	76513	
70210	76514	
70220	76516	
70360	76519	
70371	76529	

Nephrologists – specialty code 98

Procedure Codes				
Aorta and arteries	Veins and lymphatics	Radiologic guidance	Transcatheter procedures	Ultrasound
75710	75820	77001	75894	76705
75790	75822		75902	76776
	75825		75962	76937
	75827		75978	

Neurologists – specialty code 13

Procedure Codes				
Head and neck	Spine and pelvis	Radiologic guidance	Bone/joint studies	Noninvasive vascular diagnostic studies
70450	72125	77002	77080	93880
70460	72126	77003		93882
70470	72127			93886
70551	72128			93888
70552	72129			
70553	72130			
	72131			
	72132			
	72133			

Obstetricians, gynecologists, perinatologists, infertility specialists – specialty code 09, 15, 16

Procedure Codes						
Gynecological and obstetrical	Ultrasound		Screening mammography	Bone/joint studies	Echocardiography	Noninvasive vascular diagnostic studies
74740	76645	76821	77052	77080	93325	93970
74742	76801	76825	77057			93971
	76802	76826				93976
	76805	76827				
	76810	76828				
	76811	76830				
	76812	76831				
	76813	76856				
	76814	76857				
	76815	76941				
	76816	76942				
	76817	76945				
	76818	76946				
	76819	76948				
	76820					
						Other
						76376

Ophthalmologists – specialty code 18

Procedure Codes	
Ultrasound	Bone/joint studies
76510	77080
76511	
76512	
76513	
76514	
76516	
76519	
76529	

Oral surgeons – specialty code 97

Procedure Codes	
Head and neck	
70100	70310
70110	70320
70140	70328
70150	70330
70160	70332
70210	70350
70220	70355
70300	70380

Orthopedists – specialty code 20

Procedure Codes									
Chest	Spine and pelvis		Upper extremities	Radiologic guidance	Lower extremities		Ultrasound	Bone/joint studies	Other
71020	72010	72090	73000	77003	73500	73590	76880	77071	76000
71100	72020	72100	73010		73510	73592	76942	77072	
71101	72040	72110	73020		73520	73600		77073	
71110	72050	72114	73030		73540	73610		77076	
71111	72052	72120	73050		73550	73620		77077	
71120	72069	72170	73060		73560	73630		77080	
71130	72070	72190	73070		73562	73650			
	72072	72200	73080		73564	73660			
	72074	72202	73090		73565				
	72080	72220	73092						
			73100						
			73110						
			73120						
			73130						
			73140						

Physical medicine and rehabilitation physicians - specialty code 25

Procedure Codes						
Chest	Spine and pelvis	Upper extremities	Lower extremities		Radiologic guidance	Bone/joint studies
71100	72010	73000	73500	73590	77002	77071
71101	72020	73010	73510	73592	77003	77073
71110	72040	73020	73520	73600		77080
71111	72050	73030	73540	73610		
71120	72052	73050	73550	73620		
71130	72069	73060	73560	73630		
	72070	73070	73562	73650		
	72072	73080	73564	73660		
	72074	73090	73565			
	72080	73092				
	72090	73100				
	72100	73110				
	72110	73120				
	72114	73130				
	72120	73140				
	72170					
	72190					
	72200					
	72202					
	72220					

Plastic surgeons – specialty code 24

Procedure Codes					
Chest	Spine and pelvis		Upper extremities	Lower extremities	Bone/joint studies
71100	72170	72069	73000	73500	77071
71101	72190	72070	73010	73510	77073
71110	72200	72072	73020	73520	77080
71111	72202	72074	73030	73540	
71120	72220	72080	73050	73550	
71130	72010	72090	73060	73560	
	72020	72100	73070	73562	
	72040	72110	73080	73564	
	72050	72114	73090	73565	
	72052	72120	73092	73590	
			73100	73592	
			73110	73600	
			73120	73610	
			73130	73620	
			73140	73630	
				73650	
				73660	

Podiatrists – specialty code 48

Procedure Codes	
Lower extremities	
73600	73630
73610	73650
73620	73660

Primary care physicians – specialty codes 01, 03, 08, 10, 11, 39, 44, 76 and AF

Procedure Codes								
Chest	Spine and pelvis	Upper extremities	Lower extremities	Abdomen	Ultrasound	Screening mammography	Bone/joint studies	Noninvasive vascular diagnostic studies
71010	72010	73000	73500	74000	76801	77052	77080	93970
71020	72020	73020	73550	74010	76802	77057		93971
	72040	73030	73560	74020	76805			
	72050	73050	73562	74022	76810			
	72052	73060	73564		76811			
	72069	73070	73565		76812			
	72070	73080	73590		76815			
	72072	73090	73592		76816			
	72074	73092	73600		76817			
	72080	73100	73610		76818			
	72090	73110	73620		76819			
	72100	73120	73630		76937			
	72110	73130	73650		76942			
	72114	73140	73660					
	72120							
	72170							

Pulmonologists – specialty code 29

Procedure Codes	
Chest	Bone/joint studies
71010	77080
71020	
71021	
71022	
71023	
71030	
71034	
71035	
71040	

Rheumatology – specialty code 99

Procedure Code
Diagnostic ultrasound
76880

Urologists – specialty code 34

Procedure Codes				
Abdomen	Urinary tract	Ultrasound	Bone/joint studies	Noninvasive vascular diagnostic studies
74000	74400	76705	77080	93975
	74410	76770		93976
	74415	76775		93980
	74430	76830		93981
	74455	76856		
		76857		
		76870		
		76872		
		76873		
		76942		

Vascular, thoracic surgeons – specialty code 33

Procedure Codes		
Bone/joint studies	Noninvasive vascular diagnostic studies	
77080	93880	93926
	93882	93930
	93886	93931
	93888	93965
	93890	93970
	93892	93971
	93893	93975
	93922	93976
	93923	93978
	93924	93979
	93925	93990

Benefits

This section is currently under construction. For basic Medicare benefits, refer to the CMS website: [cms.hhs.gov/Manuals/IOM/list.asp](https://www.cms.hhs.gov/Manuals/IOM/list.asp)*

Structurally, Medicare Plus Blue PPO members will have member cost sharing for non-urgent or emergency services received out of network and a separate maximum out-of-pocket for out-of-network services.

Primary Care Physicians

BCBSM Medicare Advantage PPO recognizes the following practitioner specialties as personal or primary care physicians. They should provide primary care services and assist BCBSM Medicare Plus Blue PPO members' to manage/coordinate care:

- Family practice
- General practice
- Internal medicine
- Obstetrics/gynecology
- Pediatrics

Hospice services

Federal regulations require that Medicare fee-for-service contractors (Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier) maintain payment responsibility for Medicare Plus Blue PPO members who elect hospice care. Therefore, claims for services provided to a Medicare Plus Blue PPO member who has elected hospice care should be billed to the appropriate Medicare contractor. Some exceptions apply.

More specifically:

- If the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.
- If the service is not related to the member's terminal condition, submit the claim to the Medicare fiscal intermediary, administrative contractor, DME regional carrier, Part D or prescription drug plan, or another carrier as appropriate.
- If the service is provided during a lapse in hospice coverage submit the claim to the local Blue plan.
- If the service is not covered under Original Medicare but offered as an additional benefit under the member's Medicare Plus Blue PPO plan (e.g. acupuncture), submit the claim to the local Blue plan.

Access to care

CMS requires the hours of operation of its practitioners are convenient to and do not discriminate against members.

Practitioners must provide coverage for their practice 24 hours a day, 7 days a week with a published after-hours telephone number, pager or answering service. In addition, primary care physicians must provide appropriate backup for absences.

Accessibility of services is measured by the timeliness of appointments and in-office waiting times for routine, urgent and emergency care. Each practitioner must, at a minimum, meet the following standards of access and availability for all Medicare Plus Blue PPO members.

Service accessibility will be measured and monitored using the following standards:

- Emergency medical services — service is provided within two hours or less of presentation of symptoms to the practitioner.
- Urgent care services — service is provided within 24 hours.
- Non - urgent services — service is provided within one week.
- Routine, follow-up or preventive care — service is provided within 30 days.
- Average waiting time in the office is equal to or less than 30 minutes.

Medicare Plus Blue PPO allows all members direct access to primary care and specialty practitioners for in-network routine, preventive and specialty services. BCBSM encourages Medicare Advantage PPO practitioners (or their office staff) to assist members in finding a practitioner that can provide necessary services. If assistance is needed in arranging for specialty care (in- or out-of-network), please contact Provider Servicing at Blue Cross Blue Shield of Michigan.

BCBSM network providers are to ensure that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those members with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds.

Providers and their office staff are not allowed to discriminate against members in the delivery of health care services consistent with benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. It is necessary that a provider's office can demonstrate they accept for treatment any member in need of health care services they provide.

Medical management, quality, cost and safety initiatives

Care and disease management

Medicare Plus Blue PPO will offer enhanced care management programs to members in 2010. Our new care management strategy begins with our Care Transitions team reaching out to lead discharge planning for members with significant health issues. These members may be placed into a treatment plan such as a home-based provider program, remote monitoring or advanced intensity case management. BCBSM may contact you to help coordinate care for these members.

- **Care Transitions** — Care Transitions care management program seeks to identify and assist members who are being discharged from an acute admission and are at highest risk for recovery complications which could cause emergency room visits and inpatient readmissions or require post-acute care. Criteria and predictive modeling processes (including prenotifications, claims history, and demographic information) are used to identify members for this program.

Care Transitions services include:

- coordination of discharge needs
- provision of post-discharge care coordination calls
- post-discharge education on medications
- need for physician follow up
- triage for referral to other BCBSM health management programs

The first call to the member focuses on the initial discharge assessment including the member's understanding of his or her discharge instructions and plan of care. During this call the Care Transitions team will determine if any medications were obtained, if durable medical equipment and home services were prescribed for the post discharge plan of care and whether follow up appointments have been made with the physician. The second call continues the care coordination process and Care Transitions treatment plan. The third and final Care Transitions call completes the Care Transitions treatment plan.

If the member has ongoing needs that meet criteria for one of the advanced intensity programs, they are referred to the appropriate program. All other members are provided with discharge instructions and information on self-management tools. Care Transitions will then close the member's treatment plan and case.

- **Home based provider program** — The home-based provider program reaches out to members with high level chronic conditions by using physician-driven directed care complemented by nurse care management. The goal of this program is to reduce the number of readmissions and emergency room visits, decrease the level of severity and improve the quality of life for the member. HBPP serves to complement general physician care through criteria-based high risk management and an advanced illness support program.
- **Remote Monitoring** — Remote monitoring assists members with either high-intensity heart failure or high-intensity chronic obstructive pulmonary disease and who are not candidates for HBPP.

In order for the member to be considered a candidate for the remote monitoring program, we will reach out to their physician and ask them to respond as needed to alerts from the remote monitoring team related to the member's health. Outreach services provided by remote monitoring may occur by phone, in-home biometric device, and through the Internet. Remote monitoring will provide health coaching and symptom management, proactively identify and close care gaps, and assist members with becoming self-sufficient at managing their condition. This program incorporates daily monitoring of high-risk members, timely identification of clinical changes, and teachable moments between nurses and members. Members will be reevaluated every six months.

- **Case management** — The case management program assists members identified and referred by Care Transitions as having complex health issues and needs for coordination or psychosocial intervention. Services provided will include nurse-driven case management by phone or in-person to coordinate care needs and proactively identify and close care gaps. Nurse case managers may contact providers directly to coordinate care and services. Services are provided until care gaps are closed and no additional case management benefit can be derived.

The goal of the case management program is to reduce acute admissions and emergency room utilization for patients with complex health status/needs by assessing and managing opportunities to coordinate care, providing member health coaching, and promoting advanced illness decision-making regarding advance directives such as a Durable Power of Attorney.

- **Health and wellness** — Our health care management program gives members health information to help them understand their health care issues, address their concerns, and work more closely with their providers. Members can view online articles, tools and quizzes that provide information on thousands of topics. Providers may refer members to this resource, when appropriate, by having them visit the *Health Assessment & Wellness* screen at bcbsm.com.

Quality Improvement Program

The Medicare Plus Blue quality improvement program has been established to systematically and comprehensively measure, assess, and improve the quality of delivery of our Medicare Plus Blue products. The scope of our plan is to monitor and evaluate the important aspects of care and services our members receive with a focus on:

- Access to care and availability of services
- Chronic care management and case management
- Utilization management
- Member and provider satisfaction
- Improving health outcomes
- Ensure compliance with all regulatory standards.

BCBSM is committed to providing members access to high-quality, comprehensive and cost-effective medical care with their Medicare Plus Blue PPO plan.

Healthcare Effectiveness Data and Information Set

HEDIS is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. BCBSM will follow HEDIS reporting requirements established by the National Committee for Quality Assurance and Centers for Medicare & Medicaid Services. Audited HEDIS reports will be used to identify quality improvement opportunities and develop quality-related initiatives. Additional information will be communicated on specific HEDIS measures via our provider newsletter, *The Record*.

Cost and safety management

We work together with our network providers to ensure that:

- Patients receive quality services
- Benefits are administered appropriately and efficiently
- Services are billed and paid correctly
- Over-utilization is appropriately managed

Overview

BCBSM has developed the following processes and guidelines for providers to proactively communicate and obtain authorization/certification for anticipated services or admissions. The information below outlines the program guidelines for hospital admissions, as well as specialty services such as radiology, skilled nursing facility and long-term acute care admissions or acute care rehabilitation.

All medical procedures are subject to BCBSM's claim processing rules and post-payment audit. Providers risk possible recovery of funds by BCBSM during post-payment audit if clinical criteria are not met or if documentation is not maintained in the patient's medical records in accordance with CMS and BCBSM specifications.

In addition to providing a means of determining whether the patient's symptoms meet criteria for the level of care you've planned, the pre-approval process helps identify cases that may benefit from the assistance of one of our care management programs.

Preadmission notification, preauthorization and precertification

Preadmission notification

For acute care admissions to hospitals, providers are required to use our prenotification system, web-DENIS, to alert BCBSM of the admission.

While pre-approval of hospital admissions is not required, it is highly recommended that hospitals utilize InterQual® criteria to assess the medical necessity of the admission. InterQual criteria should be applied prior to executing the prenotification process, but it will not be reviewed to accept or modify the admission.

Preauthorization

Preauthorization enables physicians and other professional providers to request our review of a medical procedure or treatment before it is performed.

Preauthorization of services is based on the information you provide at the time of your request. It is not our approval to provide the service for a patient, nor is it a guarantee of payment. Your claim must still meet our usual eligibility, billing, benefit and medical guidelines to be paid.

Note: If the service is not a benefit under your patient's BCBSM contract, or if it is not medically necessary, there is no reason to request preauthorization; the service will not be covered.

Preauthorization may be mandatory for any of a number of reasons, such as:

- The contract benefit under which the proposed service falls requires preauthorization (such as high-tech radiology; SNF, LTAC, and rehab admissions).
- The BCBSM program under which the proposed service falls requires preauthorization.
- The employer group that offers coverage to your patient requires preauthorization.

Preauthorization should be requested before the service is performed.

How we notify you of the results: Our medical staff will review all preauthorization requests and respond to you by mail. If your request is approved, we'll give you a preauthorization number, which you'll later need when completing a claim form to bill for the service. For more information, see Claims. If your request is denied, we'll explain why. You may appeal our decision; see Appeals.

Note: Even if your request is denied, you may still perform the procedure. However, the patient will be responsible for the cost.

Precertification for Skilled Nursing Facility (SNF), Long -Term Acute Care Hospitals (LTAC), and Inpatient Rehabilitation (IP Rehab) Admissions

Precertification is a review of a patient's symptoms and proposed treatment to determine, in advance, whether they meet nationally recognized clinical screening criteria for SNF, LTAC, and IP rehab admission and the level of care planned.

All Michigan, Medicare Plus Blue PPO providers are required to contact the BCBSM Precertification Services department prior to admitting a Medicare Plus Blue PPO member into these facilities. Medical criteria will be utilized to assess the patient's severity of illness, the intensity of service, and discharge readiness.

The precertification process works best when hospitals and physicians have a standard procedure for communicating with each other to ensure that precertification information is sent to us on time. Please note that if we do not have the facility precertification prior to the claim submission, and there is no precertification determination on file, the claim may be rejected.

Before you call us

For precertification to be approved, the proposed service must be a benefit under the patient's active contract. Before you call to request precertification, check your patient's BCBSM coverage to verify the benefit.

Make sure that the following information is ready when you call us to request pre-certification:

Category	Necessary information
Patient	<ul style="list-style-type: none"> • Subscriber's first and last names as shown on the BCBSM ID card • Contract or ID number: usually a three-letter alpha prefix and nine digits or, for an Federal employee program member, an "R" followed by eight digits • Subscriber's street address, city, state and ZIP code • Patient's name as shown on the contract • Patient's birth date: month, day and year • Patient's sex • Patient's relationship to subscriber (self, spouse or dependent) • Date of admission or first visit for this condition (day, month, year) • Primary diagnosis: reason for treatment. Use ICD-9-CM diagnosis code.
Provider	<ul style="list-style-type: none"> • Provider's name and phone number • Provider's identification number, if applicable • Facility phone number and five-digit facility code
Hospital services (as applicable)	<ul style="list-style-type: none"> • Facility name and phone number • Facility five-digit facility code • Attending physician's name, phone number and PIN
Clinical	<ul style="list-style-type: none"> • Patient's presenting signs and symptoms • Duration, frequency, intensity of symptoms
Treatment plan	<ul style="list-style-type: none"> • Treatment goals, interventions, frequency of interventions • Estimated length of stay • Discharge plan

In situations other than medical emergencies, precertification should be requested before the SNF, LTAC, or rehab admission is executed.

Members will receive pre-certification approval letters. Providers and members will also receive written notification of pre-certification denials with all applicable level one and level two appeal rights.

Clinical criteria for Skilled Nursing Facility (SNF), Long -Term Acute Care Hospitals (LTAC), and Inpatient Rehabilitation (IP Rehab) Admissions

We use InterQual criteria to review inpatient services (except psychiatric care), rehabilitation services and skilled nursing services for precertification and recertification approval.

Certain facilities (skilled nursing, long-term acute care, home health care and rehabilitation), and BCBSM also use InterQual criteria to:

- Review admissions, monitor continued stays and for discharge screening
- Determine the appropriateness of the setting

Facilities use the criteria for first-level review. Your non-physician utilization management staff should use the criteria to ensure that the level of care is appropriate based on the clinical findings on the patient. BCBSM uses the criteria to support precertification and recertification decisions.

Criteria sets: We've contracted with McKesson Corporation to provide you with the following current InterQual Level of Care criteria sets:

- InterQual's current acute care criteria for adults and children (called InterQual AC criteria) relate to acute-care hospitalization. If you determine that you need to call us for precertification, our nurses and medical consultants review the admission to determine whether it meets these criteria. If the criteria and our medical consultant's review do not support an admission, the medical consultant may suggest an alternative level of care.
- InterQual's Acute Care book includes observation criteria. Although we do not require precertification for observation care, our nurses and medical consultants review observation services to determine whether the patient can be safely managed in this alternative setting.
- InterQual's Acute Care book also includes a list of surgical procedures for which an inpatient setting is appropriate.
- InterQual's current rehabilitation criteria for adults and children relate to inpatient rehabilitative services. Precertification is required for every rehabilitation admission. When you call us, our nurses and medical consultants review the admission to determine whether it meets InterQual criteria.

InterQual's current skilled nursing facility criteria for adults relate to skilled nursing services. Precertification and recertification are required for every skilled nursing admission. When you call us, our nurses and medical consultants review admissions to determine whether they meet InterQual criteria.

- InterQual's current home care criteria for adults and children relate to home health services. Although we require that home health care agencies apply InterQual criteria for admissions and patient management, we do not require precertification and recertification for home care services.

In addition to the level-of-care criteria, McKesson provides you with current InterQual Procedures Criteria. InterQual's current procedures criteria are available in your hospital; you're welcome to review them. Although we don't use these criteria for precertification at this time, we may use them as screening criteria during audits.

Member and provider appeals and grievances not directly related to a payment dispute

The Medicare Plus Blue PPO Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. You can call our Medicare Plus Blue Provider Inquiry at 1-866-309-1719, 8:30 a.m. to 5 p.m. for more information on our member appeals and grievance policies and procedures.

Providing members with notice of their appeals rights

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, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: 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: www.cms.hhs.gov/MMCAG/Downloads/NOMNC.pdf* and 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: www.cms.hhs.gov/MMCAG/Downloads/DENCIInstructions.pdf*.

For hospitals, to obtain the Detailed Notice of Discharge go to: 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

Failure to provide the requested forms violates the terms and conditions of your contract. Please reference your contract under the section entitled *Member Notice of Termination of Certain Covered Services*.

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 1-866-309-1719, fax your request to 1-877-894-9531 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 1-877-894-9531. 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.

Reimbursement

BCBSM reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage PPO Agreement minus any member required cost sharing, for all medically necessary services covered by Medicare or an enhanced Medicare Plus Blue PPO benefit.

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 in accordance with the Medicare PPO Provider Agreement.

BCBSM provides a Summary of Benefits 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 Plus Blue PPO plan.

BCBSM must also comply with CMS' national coverage determinations, general coverage guidelines included in original Medicare manuals and instructions, and written coverage decisions of the local Medicare Administrative Contractor (MAC).

Follow all Original Medicare billing guidelines and be sure to include the following on all claims:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code you must supply all applicable digits.
- National coding guidelines accessible at www.cdc.gov/nchs/data/icd9/icdguide09.pdf
- Medicare Part B supplier number, national provider identifier and federal tax identification number
- The member's Medicare Plus Blue 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 (08/05) claim form.

Providers affiliated with the Medicare Advantage PPO network agree to BCBSM reimbursement policies outlined in the agreement. These include:

- Accepting the applicable Medicare Plus Blue PPO reimbursement as payment in full for covered services, except for cost sharing, which is the member's responsibility
- Billing BCBSM, not the patient, for covered services
- Not billing patients for covered services that:
- Require but did not receive preapproval
- Were not eligible for payments as determined by BCBSM based upon BCBSM credentialing or privileging policy for the particular service rendered

Claim filing

Medicare Plus Blue billing guidelines and unique billing requirements may be accessed at www.bcbsm.com/ma/submitting_claims.shtml.

Where to submit a claim:

For Claims with Local Carrier Jurisdiction:

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

Medicare Advantage
Blue Cross Blue Shield of Michigan
P.O. Box 440
Southfield, MI 48037-0440

- For claims with DME MAC jurisdiction
- For paper claim submission, send claims to:
 Medicare Advantage Plus Blue
 DMEnson Benefit Management
 P.O. Box 81700
 Rochester, MI 48308-1700
- For electronic claim submission, please contact the Electronic Data Interchange Help Desk at 1-800-542-0945. An EDI user guide is also available at bcbsm.com/pdf/edi_userGuide.pdf.

Non-Michigan providers bill your local Blue plan. Report the alpha prefix to ensure correct routing of the claim.

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

Electronic Claims	
Michigan providers — Contact the Electronic Data Interchange Help Desk at 1-800-542-0945. 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	Michigan providers — contact Provider Inquiry at 1-866-309-1719 Non-Michigan providers — contact your local Blue plan
Services with CMS DME MAC jurisdiction	All providers — contact DMEnson Benefit Management at 1-888-828-7858

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

Services with CMS local carrier jurisdiction	
Michigan providers	Contact Provider Inquiry at 1-866-309-1719
Non-Michigan providers	Your local Blue plan
Services with CMS DME MAC jurisdiction	
All providers	Contact DMEnson Benefit Management at 1-888-828-7858

To do a status inquiry on a Medicare Plus Blue PPO claim you have two options:

1. Contact the Provider Inquiry area for this information by phone (866-309-1719) or in writing to the following address:
 Medicare Advantage
 Provider Inquiry Services
 P.O. Box 33842
 Detroit, MI 48232-5842
2. Use web-DENIS. Even though you can check the status of a claim, you can't adjust or correct any Medicare Plus Blue PPO claim. For facility claims click on the *Medicare Plus Blue/Medicare Advantage Claims Tracking*. For professional claims click on Claims Tracking.

Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount paid by Medicare, you have the right to dispute the payment amount by following our dispute resolution process.

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.

Medical records, audits and reviews

Medicare Plus Blue PPO providers must maintain timely and accurate medical, financial and administrative records related to services they render to Medicare Plus Blue PPO members.

Provider will maintain timely and accurate medical, financial, and administrative records related to covered services rendered by provider. Unless a longer time period is required by applicable statutes or regulations, provider shall maintain such records and any related contracts for 10 years. Provider shall give any authorized local, state, or federal government agency, including without limitation BCBSM, Health and Human Services, U.S. General Accounting Office, Centers for Medicare & Medicaid Services, and their authorized designees, the right to audit, evaluate, and inspect all physical premises, books, contracts, records, including medical records, and documentation involving transactions related to CMS' contract with BCBSM during the term of the provider agreement and for a period of 10 years following termination or expiration of the agreement for any reason, or until completion of an audit, whichever is later.

Medical record content and requirements for all practitioners (for behavioral health practitioners see below) include, but may not be limited to:

- Clinical Record
 - Patient identification, name, (with name or ID# on each page) address, date of birth or age, sex, marital status, home and work telephone numbers, emergency/next of kin/contact telephone number, guardianship information (if relevant), signed informed consent for immunization/invasive procedures, etc documentation of discussion regarding advanced directives (age 18 and older) and a copy of the advance directives.
- Medical Documentation
 - History and physical, allergies and adverse reactions, problem(s) list, medications, documentation of clinical findings and evaluation for each visit, preventive services/risk screening.
 - Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
 - Past medical/surgical/behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment and age/sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
- Documentation of patient education (age/condition specific), if applicable:
Injury prevention, appropriate dietary instructions, lifestyle factors, self exams.
- Clinical Record — progress notes
 - Identification of all providers participating in the members care and information on services furnished by these providers
 - Reason for visit/chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed, follow-up report to referring practitioner (if applicable).
- Clinical Record – report(s) content (all reviewed, signed and dated within 30 days of service or event)
 - Lab/x-ray, referrals/consultations, discharge summaries, consultations/summary report(s) from health care delivery organizations...i.e. skilled nursing, home health, free-standing surgical centers, urgent care centers.

For Behavioral Health Practitioners:

- Chief complaint, review of systems and complete history of present illness.
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills.
- At least one complete mental status examination, usually done at the time of initial evaluation and contains each of the items below:
 - Description of speech
 - Description of thought processes
 - Description of associations (e.g., loose, tangential, circumstantial, intact).
 - Description of abnormal or psychotic thoughts
 - Description of the patient’s judgment
 - Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect and other information relevant to the case.
- A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination and/or other assessment data.
- Thorough assessment of risk of harm to self or others.
- Informed consent indicating the member’s acceptance of the treatment goals. NOTE: formal signed consent is not required except where required by law.
- In order to ensure coordination of the member’s care the treatment records reflect continuity and coordination of care with the member’s primary care practitioner and, as may be applicable, and consultants, ancillary practitioners and health care institutions involved in the member’s care.
- Where it is required by law, proper written and signed consent for any release of information to outside entities has been obtained.
- Progress notes describe the member’s strengths and limitations in achieving the treatment goals and objectives.
- Members who become homicidal, suicidal, or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

General Requirements

The provider of service for all face-to-face encounters must be identified on the medical record which includes: signature and credentials (can be located anywhere on record, including stationary).

STAMPED signatures are NOT acceptable

Acceptable signatures include – handwritten, initials can be used if the full name and credentials appear somewhere in the record or on stationary, electronic signature on electronic records if authenticated at the end of each note in accordance with CMS authentication requirements (examples include – “electronically signed by, ” “authenticated by, ” “approved by, ” “completed by, ” “finalized by, ” “or “validated by, ” and includes practitioners name/ credentials dated and signed).

Patient health information and medical records must be maintained in accordance with current federal and/or state regulations/requirements (including prior consent when releasing any information contained in the medical record).

Such records may be used in:

- CMS and Medicare Plus Blue PPO reviews of risk adjustment data
- Medicare Plus Blue PPO determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service
- Making advance coverage determinations
- Reviews to verify the absence of fraud or abuse
- Other reviews deemed appropriate and/or necessary

We 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.

Other Medicare Plus Blue PPO requirements

Additional requirements pertaining to Medicare Plus Blue PPO programs are described below.

Audits

BCBSM conducts audits in accordance with Medicare laws, rules and regulations. BCBSM will conduct audits as needed including, but not limited to DRG validation audits, site of care reviews, readmission audits, audits at skilled nursing facilities or other network providers and practitioners, CMS risk-adjustment validation audits and BCBSM risk-adjustment medical reviews. BCBSM may require providers and practitioners to submit medical records for these audits.

CMS risk-adjustment validation audits — CMS makes advance monthly payments to Medicare Plus Blue PPO plans for coverage of Original fee-for-service benefits for an individual in a Medicare Plus Blue PPO payment area for a month. CMS may require MAOs and their providers and practitioners to submit medical records for the validation of risk adjustment data. There may be penalties for submission of false data.

BCBSM risk-adjustment medical reviews — From time to time, BCBSM may require providers to make records available for on-site review or submission to ensure claims submitted are consistent with the chronic conditions documented in the medical record. BCBSM may reimburse providers for administrative costs related to these audits and reviews.

Cost settlement

Original Medicare makes estimated (interim) payments to hospitals and clinics when claims are submitted which are at least partially reimbursed based on their reasonable costs rather than a fee schedule. The Medicare fiscal intermediary attempts to make the interim payments as accurate as possible. After the hospital's fiscal year ends, the fiscal intermediary settles with the provider for the difference between interim payments and actual reasonable costs.

CMS policy does not require Medicare Plus Blue PPO plans to agree to conduct cost settlement with providers. Therefore, following the fiscal intermediary settlement, except as stated in the Hospital Reimbursement Provisions section of this manual, BCBSM will not pay providers, and

providers will not pay BCBSM for the difference between interim payments and actual reasonable costs. The fiscal intermediary will not include Medicare Plus Blue PPO members in their settlements with providers.

Hospital reimbursement provisions

In the instance where certain provisions of the Original Medicare reimbursement system (for example, disproportionate share, bad debt, etc.) are not accounted for through the normal voucher system, the following procedures will be required for the hospital to receive payment:

The hospital will notify BCBSM on an annual basis in writing of the discrepancy. The information must be submitted to BCBSM within 180 days of the hospital's fiscal year end and must include all of the following:

- A description of the issue
- An estimate of the impact

- Supporting documentation including (as appropriate):
 - The filed Medicare cost report for the year in question
 - The Medicare interim rate letter for the applicable time period
 - A detailed claims list
 - Calculations showing how the impact amount was determined

BCBSM will review the information and give the hospital a written determination within 180 days from the date the notification is received. If the discrepancy is expected to span multiple years into the future, BCBSM will consider adjusting the interim rates paid to the hospital in order to voucher/pay the amount in question through the normal voucher system.

For sole community hospitals and critical access hospitals, BCBSM recognizes that these hospitals have a potentially material settlement with Medicare as supported by their Medicare cost report. BCBSM, through the normal voucher/payment process, will work with the hospital to include an amount on the voucher that reflects as closely as possible the amount that would have been paid under the Original Medicare payment system (excluding any BCBSM specific programs such as any future incentive program). In the event that there is a material difference in the amount paid throughout the hospital's fiscal year between what was on the voucher and what would have been paid under Original Medicare, the hospital will notify BCBSM on an annual basis in writing within 180 days of the hospital's fiscal year end. The notification must include all of the following:

- A description of the issue
- An estimate of the impact
- Supporting documentation including (as appropriate):
 - The filed Medicare cost report for the year in question
 - The Medicare interim rate letter for the applicable time period
 - A detailed claims list
 - Calculations showing how the impact amount was determined

BCBSM will review the information and give the hospital a written determination within 180 days from the date the notification is received.

Serious Adverse Events and Present on Admission

Blue Cross Blue Shield of Michigan developed an enterprise wide reimbursement policy. BCBSM does not pay for medically unnecessary services, regardless of the cause. This policy is in keeping with BCBSM reimbursement structure under the Participating Hospital Agreement and provider contracts.

The main provisions of the policy are as follows:

1. BCBSM will no longer reimburse a hospital or physician whose direct actions result in a serious adverse event.
2. Serious adverse events affected by this policy will change consistent with changes made by the Center for Medicare & Medicaid Services.
3. BCBSM participating hospitals are required to report present on admission indicators on all claims.
4. BCBSM participating hospitals are not to balance bill members for any incremental costs associated with the treatment of a serious adverse event that BCBSM has paid.
5. BCBSM members who have been billed in error should report incidents to BCBSM as appropriate.

The policy on serious adverse events applies to all acute care hospitals, exempt hospital units and critical access hospitals that have signed a BCBSM participating hospital agreement.

BCBSM developed the following list of events and conditions:

- Object left in after surgery
- Air embolism as a result of surgery
- Blood incompatibility
- Catheter associated urinary tract infections

- Pressure sores (decubitus ulcers) – Stage 3 or 4
- Vascular catheter associated infections
- Surgical site infections
 - Mediastinitis following a coronary artery bypass graft (CABG) surgery
 - Gastric bypass
 - Orthopedic procedures
- Hospital acquired injuries
 - Falls and fractures
 - Dislocations
 - Intracranial and crushing injury
 - Burns
- Deep vein thrombosis or pulmonary embolism following:
 - Total knee replacement
 - Total hip replacement
- Extreme blood sugar derangement
- Diabetic ketoacidosis
 - Nonketotic hypersolmar coma
 - Hypoglycemic coma
 - Secondary diabetes with ketoacidosis
 - Secondary diabetes with hyperosmolarity

Additionally, CMS further defined the following events for wrong surgeries for easier identification:

- Performance of operation (procedure) on patient not scheduled for operation (procedure) –formerly known as surgery on wrong patient
- Performance of correct operation (procedure) on wrong side or body part – formerly known as surgery on wrong body part
- Performance of wrong operation (procedure) on correct patient – formerly known as wrong surgery

Clinical research study

If a member with Medicare Plus Blue PPO coverage participates in a Medicare-qualified clinical research study, Original Medicare will pay the provider on behalf of the Medicare Plus Blue PPO plan. The Medicare Plus Blue PPO plan will pay for Medicare-covered services that are not affiliated with the clinical trial. Providers need to submit bills to carriers and fiscal intermediaries using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to BCBSM and BCBSM will reimburse providers accordingly.

Swing beds

Swing beds in a critical access hospital are paid according to the critical access hospital methodology (101 percent cost).

Swing beds located in non-critical access hospitals are paid using the Medicare Skilled Nursing Facility Prospective Payment System, which is a per diem payment.

Network participation

Overview

BCBSM will give select provider types an opportunity to apply for participation in the Medicare Advantage PPO network. Network providers provide care to Medicare Plus Blue PPO members and we reimburse them for covered services at the agreed upon payment rate. Network providers sign formal agreements with BCBSM, agree to bill us for covered services provided to Medicare Plus Blue PPO members, accept our reimbursement as full payment minus any member required cost sharing, and receive payment directly from BCBSM.

Qualifications and requirements

In order to be included in BCBSM's Medicare Advantage PPO network, providers must:

- Have a national provider identifier they use to submit electronic transactions to BCBSM (in accordance with HIPAA requirements) or to submit paper claims to BCBSM.
- Meet all applicable licensure requirements in the state of Michigan and meet BCBSM's credentialing requirements pertaining to licensure.
- Furnish services to a Medicare Plus Blue PPO member within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care.
- Provide services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare approval or certification requirements.
- 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.
- Sign formal agreements with BCBSM.
- Agree to bill us for covered services provided to Medicare Plus Blue PPO members
- Accept our reimbursement as full payment less any member cost sharing
- Receive payment directly from BCBSM
- Not be on the Department of Health and Human Services 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 BCBSM to resolve any Medicare Plus Blue PPO member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities, provide applicable member appeals notices.
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy.
- Provide certain special services to members only if approved by Medicare to provide such services (e.g., transplants, VAD distribution therapy, carotid stenting, bariatric surgery, PET scans for oncology, and/or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Be in good standing with BCBSM and meet and maintain all BCBSM credentialing requirements for network inclusion. Examples of being in good standing are:
 - Unrestricted license to practice
 - Not on pre-payment utilization review or in the performance monitoring program
 - Not denied or disaffiliated from the TRUST program within a two-year period of application to Medicare Advantage PPO

- No Medicare/Medicaid exclusion/sanction/debarment
- Not opting out of Medicare
- Agree to accept all Medicare Plus Blue PPO members unless practice is closed to all new members (commercial or Medicare).

Participation agreements

The Medicare Advantage PPO Participation Agreement includes a base agreement that applies to all providers and an attachment specific to certain provider types which may be accessed at www.bcbsm.com/ma/mpb_contract_amendments.shtml.

- BCBSM Medicare Advantage PPO Provider Agreement
- BCBSM Medicare Advantage PPO Provider Agreement Attachments
 - Practitioner Attachment
 - Hospital Attachment (includes psychiatric hospitals)
 - Non-Hospital Facility Attachment
 - Rural Health Clinic Attachment
 - Federally Qualified Health Clinic

Network information and affiliation

Overview

A Medicare Advantage PPO is a network of health care providers consisting of primary care physicians, specialists, hospitals and other health care providers who have agreed to provide services to Medicare Plus Blue PPO members. The Medicare Advantage PPO focuses on delivering cost-effective and quality patient care. Network providers agree to accept BCBSM reimbursement as payment in full for covered services (minus any member required cost sharing). Members with Medicare Plus Blue PPO coverage receive services from a select network of providers. Medicare Advantage PPO requirements apply only to providers in our Medicare Advantage PPO network.

Network sharing with other Blue plans' PPO programs

All Blue Medicare Advantage PPO plans will participate in reciprocal network sharing. This network sharing will allow all Blue Medicare Advantage PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue Medicare Advantage PPO Plan, as long as the member sees a contracted Medicare Advantage PPO provider.

If you are a contracted Medicare Advantage PPO provider for Medicare Plus Blue PPOSM and you see Medicare Advantage PPO members from other Blue plans, these members will be extended the same contractual access to care and you will be reimbursed in accordance with the rate for your Medicare Advantage PPO contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted Medicare Advantage PPO provider for Medicare Plus Blue PPO and you provide services for any Blue Medicare Advantage PPO members, you will receive the Medicare-allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

Affiliation

Eligible practitioners: Practitioners eligible for affiliation in the Medicare Advantage PPO Network are:

- Medical doctors
- Doctors of osteopathy
- Doctors of podiatric medicine
- Doctors of dental surgery (oral surgeons only)
- Doctors of chiropractic medicine
- Anesthesia assistants

- Audiologists
- Certified nurse practitioners
- Certified nurse midwives
- Certified registered nurse anesthetists
- Independent physical therapists
- Occupational therapists
- Optometrists
- Fully licensed psychologists
- Licensed master social worker
- Physician assistants
- Ambulance

Practitioner requirements: Practitioners (except ambulance) who request affiliation in the Medicare Advantage PPO Network must meet specific network requirements and complete an on-line application on the Council for Affordable Quality Health Care Universal Credentialing Datasource (CAQH UCD) Web site. Typically, up to five years of history are reviewed during the initial credentialing process. We use the same review process to credential new applicants and to re-credential network practitioners.

Practitioners must also submit a completed *BCBSM Professional Enrollment and Change Form* and a signed and dated *Medicare Advantage PPO Network Signature Document*. They must submit additional documentation as requested during the credentialing or re-credentialing process.

Facility affiliation

Facilities eligible for affiliation in the Medicare Advantage PPO network are:

- Ambulatory Surgical Facilities (freestanding only)
- End Stage Renal Disease facilities
- Federally Qualified Health Centers
- Home Health Care Facilities
- Hospitals
- Long-Term Acute Care Hospitals
- Outpatient Physical Therapy Facilities
- Rural Health Clinics
- Skilled Nursing Facilities

Facility enrollment: Information on how to enroll is available in the provider enrollment section of **bcbsm.com** at www.bcbsm.com/provider/enrollment/index.shtml.

Affiliation requirements include:

Facility

- Requirements that must be met to participate in the Medicare Advantage PPO network are available in the applications which can be found in provider enrollment section of **bcbsm.com** at www.bcbsm.com/provider/enrollment/index.shtml.

Practitioner

- BCBSM Registered — must be or become registered with BCBSM and have an active identification number. To become registered, go to **bcbsm.com**, click on the “Provider” tab and follow the appropriate links.
- Board certified — MD, DO, DPM, and DDS/DMD (oral surgeons only) must be board certified or eligible for board certification at the time of credentialing, and maintain board certification throughout affiliation. (Exception: Current BCBSM PPO TRUST Network practitioners who are not board certified are excluded from this requirement as long as they have continued affiliation in the PPO TRUST Network.)

- Fully licensed — must be fully licensed and free of any current disciplinary actions of suspension, revocation, surrender, limitation or probation. A provider who has any of these disciplinary actions imposed because of a criminal conviction related to payment or provision of health care will be restricted from applying to the network for a period of two years following the date the license restriction is lifted.
- Malpractice coverage — must have and maintain current malpractice coverage of \$100,000 per occurrence, and \$300,000 annual aggregate. The coverage must protect the provider from all liability, whether a claim is filed against the individual provider or jointly with a hospital. Liability insurance must cover all practice locations, unless the provider is directly employed by a hospital and practices exclusively at that hospital.
- Professional certification bodies — Non-physician providers must be in good standing with designated professional certification bodies applicable to their area of expertise.
- Government sanctions — must be free of any exclusions or sanctions from Medicare and Medicaid.
- Opt out — must 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.
- Prepayment utilization review — An applicant who is currently in or has a significant history in the BCBSM prepayment utilization review program will be denied affiliation with the Medicare Advantage PPO network.
- BCBSM de-participation — An applicant with a current or significant history of formal de-participation action by BCBSM will not be accepted in the Medicare Advantage PPO network.
- Malpractice case history — must be reported with supporting details. These include the number of malpractice cases against the applicant that have been filed, adjudicated or settled within the five years prior to the application date. We review all cases against established screening criteria and may deny the application. The screening criteria is; one million dollars or more, paid within a five-year period prior to application to the Medicare Advantage PPO network.
- Substance abuse or chemical dependency — Current use or recent history of illegal drug use or substance abuse or dependence will result in a denied application. New applicants with history of chemical dependence or substance abuse must:
 - Provide proof of treatment
 - Be substance-free during the 24-month period before application
 - Attest that they have no current chemical dependence and are currently free of all illegal chemicals
- Additional considerations — We may use other information in credentialing and re-credentialing review and decision-making, such as:
 - National Practitioner Data Bank findings
 - No history of conduct that threatens patient safety or adversely affects BCBSM’s business interests

Affiliated Provider Agreement: As an affiliated provider, you agree to (among other things):

- Meet our re-credentialing requirements every three years (includes facilities).
- Meet and maintain board certification requirements.
- Abide by the Medicare Advantage PPO Network agreement, policies and procedures (includes facilities).
- Bill only for professional services personally provided by the Medicare Advantage PPO Network provider. This specifically prohibits billing for services provided by any subcontractor, or other provider, including a partner in a group practice.
- Note: The only exception is when a physician personally supervises a provider who cannot bill BCBSM directly.
- Provide complete care within the Medicare Advantage PPO provider’s specialty and do not systematically refer or “share” the care of patients.
- Provide safe, medically necessary and cost-effective care (includes facilities).
- Maintain a current and accurate CAQH UCD record - update the CAQH UCD minimally once every 120 days and re-attest to the completeness and accuracy of the information.

Disaffiliation

BCBSM or an affiliated provider may terminate the BCBSM Medicare Advantage PPO provider agreement. When the agreement is terminated, the provider is no longer affiliated with the Medicare Advantage PPO network. We call this activity disaffiliation. There are two types of disaffiliation:

- Voluntary — Initiated by the provider at any time with 60 days written notice to BCBSM, or as otherwise provided in the Medicare Advantage PPO Provider Agreement except during the initial term of the agreement.
- Involuntary — Initiated by BCBSM in accordance with the Medicare Advantage PPO Provider Agreement and applicable internal policies.

Questions, additional information and contacts

BCBSM does not prohibit network health care professionals from advising or advocating on behalf of patients. If you have general questions about Medicare Plus Blue PPO, contact Medicare Plus Blue Provider Inquiry at 1-866-309-1719 (8:30 a.m. – 5 p.m.) or write to:

Medicare Plus Blue PPO
Provider Inquiry
P.O. Box 33842
Detroit, MI 48232-5842

For questions relating to DME issues, call DMEnson Benefit Management at 1-888-828-7858 (8:30 a.m. – 5 p.m.) or write to:

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

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

Services with CMS local carrier jurisdiction		
Michigan providers	Write to: Medicare Plus Blue PPO Provider Inquiry P.O. Box 33842 Detroit, MI 48232-5842	Or call: 1-866-309-1719
Non-Michigan providers	Your local Blue plan	
Services with CMS DME MAC jurisdiction		
All providers	Write to: Medicare Plus Blue PPO DMEnson Benefit Management P.O. Box 81700 Rochester, MI 48308-1700	Or call: 1-888-828-7858



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