Blue Cross Blue Shield of Michigan

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Non-Michigan providers: Prior authorizations, claim submissions, helpful resources and more

For Medicare Plus Blue℠

Revised April 2024

In this document

This document contains information about prior authorizations, requests for durable medical equipment, preservice and post-service appeals and claims submissions. It also includes helpful resources and information about changes resulting from the end of the COVID-19 public health emergency.

Prior authorizations

To determine whether prior authorization is required for a service for a Medicare Plus Blue member, see the document titled Determining prior authorization requirements for members, which you can find on our **ereferrals.bcbsm.com** website. The sections for outside of Michigan providers include step-by-step instructions.

When submitting prior authorization requests, always include complete clinical documentation to support medical necessity.

Durable medical equipment

For DME requests, submit a complete medical record with clinical documentation that supports medical necessity, per Medicare requirements. Medicare no longer requires a *Certificate of Medical Necessity* and other specific DME forms as of Jan. 1, 2023.

Durable medical equipment suppliers should file claims with the Blue plan in the state where the equipment or supplies were shipped (including mail order supplies) or purchased (if purchased at a retail store).

Appeals

- **Preservice appeals:** All providers must submit preservice appeals directly to Blue Cross Blue Shield of Michigan.

Post-service appeals

- Non-Michigan providers who **are contracted** with a Blue plan Medicare Advantage PPO should submit post-service appeals to their local Blue plan.
- Non-Michigan providers who **are noncontracted** with a Blue plan Medicare Advantage PPO should submit post-service appeals directly to Blue Cross Blue Shield of Michigan.
- For **inpatient service requests for acute medical/surgical hospital admission level of care** denied based on medical necessity, all providers should submit post-service appeals to Blue Cross Blue Shield of Michigan following the instructions in the denial letter.

Claim submissions

Non-Michigan providers should submit claims to their local Blue plan under their current billing practices. Don't bill Medicare directly for any services provided to a Medicare Plus Blue member.

Blue Cross Blue Shield of Michigan follows the guidelines published in the *Medicare Claims Processing Manual* (100-04 | CMS*) as well as Medicare National Coverage Determinations / Local Coverage Determinations (Medicare Coverage Determination Process | CMS*).

To reduce the chance of a claim denial:

- Refer to CMS guidelines to confirm which services require medical records and other criteria.
- Submit all required supporting medical documentation with the initial claim.
- Ensure that all appropriate diagnosis codes, procedure codes and modifiers (if applicable) are included on the initial claim.
- Refer to CMS coding guidelines to prevent unbundling and other coding errors. Bill in the same manner as you would bill Medicare.
- Before submitting a duplicate claim, allow 30 to 45 days for the initial claim to be processed and a determination to be made.

Helpful resources

Review the most recent requirements and procedures in the following resources:

- Fact Sheet — Includes important information for providers who treat Medicare Plus Blue individual and group members who travel or live outside of Michigan
- Prior authorization requirements for Michigan and non-Michigan providers
- Medicare Plus Blue PPO Provider Manual — Although primarily intended for use by Michigan providers, this document includes information for non-Michigan providers

Changes resulting from the end of the COVID-19 public health emergency

Many of the flexibilities and waivers that were put in place during the COVID-19 public health emergency, or PHE, ended when the PHE ended on May 11, 2023, unless the U.S. government extended them or made them permanent (for example, telehealth flexibilities). For services provided to Blue Cross Blue Shield of Michigan members on and after May 12, 2023, normal plan rules apply.

Note that the following utilization management requirements resume on July 1, 2023:

- Clinical review is required for acute medical inpatient admissions related to COVID-19, flu, pneumonia or respiratory syncytial virus.
- Standard time frames for submitting appeals of prior authorization determinations apply. Refer to the denial letter to determine the time frame.

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