Blue Cross Blue Shield of Michigan

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Blue Cross Blue Shield of Michigan's

Medicare Plus Blue℠ PPO Provider Manual

July through September 2025

This provider manual is subject to change. To ensure that you review the most current version, we strongly discourage you from relying on printed versions.

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About this manual

Overview

This manual is for use by Michigan providers only. Many of the provisions do not apply to providers in other states.

Out-of-state providers

If you are an out-of-state provider, for more information, please visit: bcbsm.com/amslibs/content/dam/public/providers/documents/medicare-plus-blue-ppo-fact-sheet.pdf.

Blue Dot change

The blue dot symbol denotes a change in a policy or procedure for this quarter.

Medicare Plus Blue℠ PPO overview

General information

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. Blue Cross will offer Medicare Plus Blue coverage to Medicare-eligible Michigan residents and Medicare-eligible members of Blue Cross groups.

Our medical policies follow Medicare Advantage Policy Guidelines to comply with CMS policy, National Coverage Determinations and /or Local Coverage Determinations. See the Medicare Coverage Database** for the most current NCD, LCD, Local Coverage Articles and CMS Online Manual System/Transmittals.

When coverage criteria are not fully established by Medicare statutes, NCDs or LCDs, we develop medical necessity guidelines that provide clinical benefits that are highly likely to outweigh any clinical harms, including those from delayed or decreased access to items or services. To access our Medicare Medical Policies and additional criteria to determine if a service is medically necessary, visit our Medical Policy Router Search page.

Medicare Plus Blue 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 Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit. You can find these enhanced benefit policies here: Enhanced Benefits.

ID card

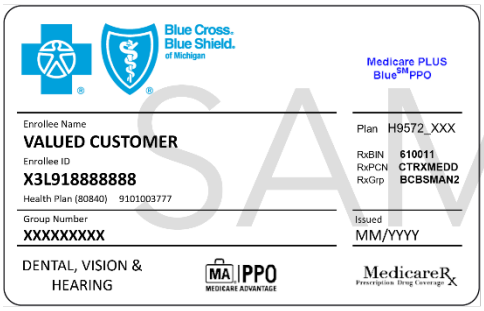
Our member identification cards contain basic information you will need when providing covered services to our members. The Medicare Plus Blue PPO ID card indicates the member is enrolled in a Blue Cross Medicare Plus Blue plan. Our Medicare Plus Blue members need to show only our ID card to receive services. They don't need to show their Original Medicare ID card.

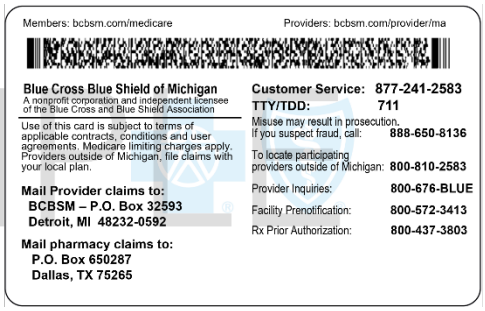
All Blue Cross Blue Shield Association (the national organization for all Blue plans) cards have a similar look and feel, which promotes nationwide ease of use. The cards include a magnetic stripe on the back to provide easier access to eligibility and benefit information.

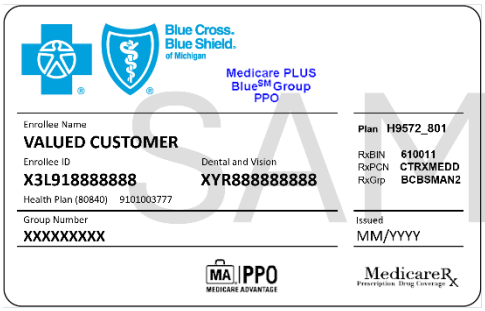
Providers must include the three-character prefix found on the member's ID card when submitting paper and electronic claims. The prefix helps facilitate prompt payment and is used to identify and correctly route claims and confirm member coverage. It is critical for the electronic routing of specific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

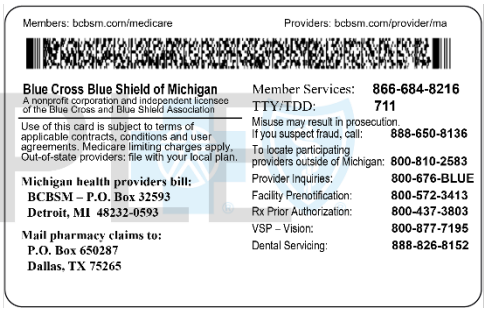
Note: We transitioned our Medicare Plus Blue individual and national Michigan group membership from ikaSystems to the NASCO system effective Jan. 1, 2025. These members have received new ID cards that must be used in claims submission. Providers will also receive updated payment vouchers on the NASCO system. Find more information on changes to the provider vouchers in the October 2024 *The Record*.

Below are samples of the new individual plan members' ID card and the national Michigan group 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 Blue

Cross 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, which identifies which Blue plan issued the card
- A Medicare Rx symbol in the lower right corner that identifies the member has prescription drug coverage (for use by pharmacists)
- The group number
- Our website address
- A magnetic stripe at the top
- Phone numbers
- An address showing where to send claims

Please note that our Michigan Public School Employees Retirement System members have a slightly different ID card.

The State of Michigan retirees' Medicare Advantage plan, called State Health Plan Medicare Advantage PPO, provides coverage for medical and surgical benefits (Part C). This plan does not administer their prescription drug coverage (Part D). The State of Michigan administers their prescription drug benefits separately from this plan. State Health Plan Medicare Advantage PPO members have "State Health Plan MA" in the middle of the ID card on the right side.

The University of Michigan now offers our Medicare Plus Blue plan to its retirees, effective Jan. 1, 2024. These plans provide coverage for medical and surgical benefits. Magellan Rx, an independent company, administers the group's prescription drug benefits.

The U of M retirees will have ID cards that indicate “Medicare Plus Blue Group PPO.” The group number is 007005187, and the alphanumeric prefix of the enrollee ID is X3L.

Eligibility and coverage

Check patient coverage at each visit

Each time your patient receives care, check 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.

Michigan providers can verify eligibility and check coverage by using our provider portal on Availity Essentials™. Availity is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Non-Michigan providers can call 1-800-676-BLUE (2583).

Availity Essentials provider portal

Our provider portal, Availity Essentials, is a dedicated payer space with tools and resources specific to Blue Cross and BCN. It provides the information listed below and more:

- Cost-sharing amount for services
- Total deductible amount
- Remaining amount of the deductible
- Out-of-pocket maximums
- Remaining amount of the out-of-pocket maximum
- Applicable prior authorization and certification requirements

Within our provider portal, you can also:

- Verify eligibility and coverage
- Check a member’s prior authorization requirements for specific procedures
- Submit clinical editing appeals, including scanning and uploading documents related to these appeals
- Perform claim status inquiries
- View remittances

New Availity Essentials users

Providers who don’t have access to Availity Essentials should register for access as soon as possible. Select an Availity Essentials administrator for

your office. Have the administrator register and then add users and user roles. For details, go to Register for Web Tools.

Provider Inquiry

To contact Provider Inquiry, call **1-866-309-1719**. Provider Inquiry can answer many questions regarding claims, benefits and cost-sharing through the automated interactive voice response system.

For claims, the automated response system provides:

- General claims information
- Claim status
- Payment and denial details

For benefit and cost-sharing information, the automated response system provides:

- Deductible and coinsurance amounts
- Remaining deductible amounts
- Out-of-pocket maximums
- Remaining out-of-pocket maximum amounts
- High-level benefit information such as office visits and preventive care services
- Copayments required for covered services

Through the automated response system, providers can also request an emailed or faxed copy of the information provided.

If you need more information after using the automated response system, you have the option of transferring to a customer service representative during business hours for additional assistance.

Dental electronic inquiry system

To check patient benefit and eligibility information, submit claims, review claim and payment status and recent communications, register here** for a DentaQuest account. Once registered, visit the dental provider portal at provideraccess.dentaquest.com.**

For dental provider servicing and automated information, call **1-844-876-7917** Monday through Friday, from 8 a.m. to 5 p.m. Eastern time. Automated information is available 24/7.

Verifying eligibility and coverage for out-of-area members

To determine eligibility and cost-sharing amounts for out-of-area members, call the nationwide network of Blue Plan providers via the Blue Cross and Blue Shield Association at **1-800-676-BLUE** (2583) and provide the member's three-digit prefix located on the ID card. You may also submit electronic eligibility requests for Medicare Plus Blue PPO members.

Billing members

Collect deductible, copayments or coinsurance 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 fixed-dollar copayment, a percentage coinsurance or a deductible. Collect only the applicable Medicare Plus Blue PPO cost-sharing amounts from the member at the time of the service.

Non-Michigan providers: After collecting these amounts, bill your local Blue plan for covered services.

Balance billing is not allowed

Collect only applicable cost sharing from Medicare Plus Blue PPO members for covered services. Do not otherwise charge or bill them.

Cost sharing for Qualified Medicare Beneficiaries (QMB) is not allowed

The Qualified Medicare Beneficiary (QMB) Program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. Federal law prohibits Medicare providers from collecting Medicare Part A and Part B coinsurance, copayments and deductibles from those enrolled in the QMB Program, including those enrolled in Medicare Advantage and other Part C plans. As mandated by CMS, providers who inappropriately bill individuals enrolled in QMB are potentially subject to sanctions. Any wrongfully collected deductibles should be refunded to the patient. Providers needing to verify a Medicare Plus Blue member's QMB status should contact Provider Servicing.

Dental billing

Dentists may refuse to accept assignment on a claim and direct Blue Cross payments to members. In this case, Blue Cross pays the approved amount, minus any applicable copayment and/or deductible directly to the member. Members are responsible for the difference between our payment and the submitted charge.

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.

CMS preclusion list

CMS adopted a rule in April 2018 that stipulates providers can't receive payment from a Medicare plan if they appear on a preclusion list managed by CMS. The preclusion list names providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. CMS made the preclusion list available to Part D sponsors and Medicare Advantage plans beginning Jan. 1, 2019.

Once Blue Cross Blue Shield of Michigan receives the preclusion list on the first of each month, our Provider Enrollment and Data Management

department will send a letter within 30 days to any contracted Medicare Plus Blue PPO provider who is on the list. The letter will include the effective date of the provider's preclusion, which will be 90 days from the date of the published preclusion list.

We're required to remove any contracted provider who is included on the preclusion list from our networks. We're also required to notify enrollees who have received care in the last 12 months from a contracted provider or a prescription from a provider who is on the preclusion list.

In addition, effective as of April 1, 2019:

- Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.
- Medicare Advantage plans will be required to deny payment for a health care item or service given by an individual or entity on the preclusion list.

Find more information on the Preclusion List here.**

Providing Medicare Outpatient Observation Notice (MOON)

The Medicare Outpatient Observation Notice (MOON) is a standardized notice developed to inform beneficiaries (including Medicare Advantage health plan enrollees) that they are in the emergency department or an outpatient receiving observation services and are not an inpatient of the hospital or critical access hospital (CAH). Blue Cross follows CMS guidance for the MOON. Hospitals and CAHs are required to furnish the MOON to Medicare beneficiaries in the circumstances listed below:

- When a member is in the emergency department and is being considered for inpatient admission. Specifically:
    - Any member considered for inpatient admission should be given the Medicare Outpatient Observation Notice form unless Blue Cross has authorized the admission.
    - If Blue Cross has approved an inpatient admission, no notification with the Medicare Outpatient Observation Notice is required.
    - If approval for inpatient admission has been requested but not received, the hospital must present the member with the Medicare Outpatient Observation Notice.
- When a member is in an observation setting for 24 hours or more, if the member has not already received the form prior to being admitted for observation.

For our Medicare Advantage members in these circumstances, hospitals must present the member with a completed Medicare Outpatient Observation Notice. This is a CMS requirement.

The notice must be provided no later than 36 hours after emergency department or observation services are initiated, or sooner if the member is transferred, discharged or admitted.

The MOON informs beneficiaries of the reason(s) they are an outpatient receiving observation services and the implications of such status with regard to Medicare cost sharing and coverage for post-hospitalization skilled nursing facility (SNF) services. Provider compliance with this notification requirement is mandatory.

Click here** for the standard language for the MOON and instructions.

Non-covered services and referrals for non-covered services — provider responsibilities

Sometimes you and your patient may decide that a service, treatment or item is the best course of care, even though Medicare Plus Blue doesn't cover it or another provider or practitioner may supply it.

You are responsible for determining which items, services or treatments are covered. If you believe that a service, item or treatment won't be covered, you must tell the member before the service or treatment is performed or item obtained. If the member acknowledges that the item, service or treatment won't be covered by Medicare Plus Blue and would like to pursue the non-covered course of treatment, then the provider would need to submit a pre-service organization determination (also known as an advanced coverage determination).

If you provide an item, treatment or service that is not covered and have not provided the patient with prior notice that the item, treatment or service is not (or may not be) covered by the plan, you may not bill the patient for such non-covered items, treatments or services.

If you believe that an item, service or treatment won't be covered and the provider supplying the item, service or treatment is not contracted with Medicare Plus Blue, you must tell the member before you refer him or her. If the member acknowledges that the item, service and/or treatment won't be covered by Medicare Plus Blue, understands that you are referring him or her to a non-contracted provider and agrees that he or she will be solely responsible for paying for the service, then you or the rendering provider must obtain an advance coverage determination before the service or item is provided.

See below for the process to request an advance coverage determination.

Getting an advance coverage determination

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before providing a service or item.

All Blue Cross Medicare Advantage PPO plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B). If the service or item provided meets Original Medicare medical necessity criteria, Medicare Plus Blue will cover it.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To obtain an advance coverage determination, fax your request to 1-877-348-2251 or submit your request in writing to:

Grievances and Appeals Department
Attn: Org Determination
Blue Cross Blue Shield of Michigan
P.O. Box 2627
Detroit, MI 48231-2627

Blue Cross 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 Blue Cross' 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 1-877-348-2251. We will notify you of our decision within 72 hours, unless the member requests a 14-day extension, or the plan justifies a 14-day extension is in the best interest of the member.

Durable medical equipment, prosthetics & orthotics and diabetes supplies

Overview

Blue Cross has contracted with Northwood, Inc., to manage requests for durable medical equipment and prosthetics and orthotics. All Medicare Plus Blue plans include coverage for DME/P&O that are covered under Original Medicare.

For DME/P&O authorization requests, providers must submit all required clinical documentation that supports medical necessity and appropriateness for treatment of the member's diagnosis. Blue Cross, or our delegated entity, must receive this information with the request in order to respond within certain time frames required by CMS.

For details on submitting authorization requests for DME/P&O, see the Getting Started page of ereferrals.bcbsm.com.

Claims for members residing outside of Michigan continue to be billed through the nationwide network of Blue Plan providers via the Blue Cross and Blue Shield Association.

DME POS benefits

For provider inquiries and to identify a contracted DME supplier, contact Northwood at **1-800-393-6432** from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. The contracted DME supplier submits the request to Northwood for review through Northwood's provider portal. Providers

can also access Northwood's provider portal through Blue Cross' provider portal (availity.com**) on the Applications tab.

Northwood processes claims for durable medical equipment and prosthetics and orthotics obtained through its contracted provider network for members residing in Michigan (items shipped to a Michigan residence or picked up from a retail store in Michigan). Northwood will reimburse its network providers in accordance with the applicable fee schedule. Providers not contracted with Northwood (but servicing a Michigan residing member) will continue to bill claims to Blue Cross directly. Out-of-network claims for Medicare Plus Blue PPO members will be reimbursed using the Medicare fee schedule with the potential for higher out-of-network cost sharing to be applied.

Continuous glucose monitor products

Medicare Plus Blue members must obtain their continuous glucose monitor products through a participating network pharmacy.

As of Oct. 1, 2024, Blue Cross Blue Shield of Michigan no longer covers CGM products dispensed by contracted and noncontracted DME suppliers for Medicare Plus Blue members.

Exception: UAW Retiree Medical Benefits Trust members are excluded from this change. These members should continue to obtain their CGM products through a DME supplier.

For more information, refer to the CGM products FAQ for prescribing providers.

Lab services

Medicare Plus Blue lab network

We've established a laboratory network with Joint Venture Hospital Laboratories, LabCorp and Quest Diagnostics, to provide outpatient laboratory testing services. JVHL provides non-patient clinical and pathology lab services defined as specimens that are either couriered to a lab or are drawn at patient service centers, including those located on hospital campuses (if no concurrent diagnostic services are rendered by a physician or non-physician practitioner). Medicare Advantage PPO providers must use the Medicare Plus Blue lab network for all lab and pathology services (facilities – nonpatient only) to receive payment. Use of the Medicare Plus Blue lab network minimizes out-of-pocket costs for members.

Locations of patient service centers are available on each of the companies' websites or by calling their administrative offices:

Company (with website)	Phone number
JVHL**	1-800-445-4979
LabCorp**	1-888-LabCorp (1-888-522-2677)
Quest Diagnostics**	1-866-MY-QUEST (1-866-697-8378)

No or minimal cost sharing is applied when Medicare Plus Blue members have lab services performed within the Medicare Advantage PPO lab network. For lab services performed at a Medicare Advantage network hospital that does not participate with the in-network preferred labs (JVHL/Quest), a copayment will apply. Coinsurance is applied when members go outside of the network. The member may visit JVHL online at jvhl.org** to view the complete list of JVHL hospital labs or call JVHL at 1-800-445-4979 for the provider directory of hospital labs that par with JVHL. See below for applicable member cost sharing.

Medicare Plus Blue PPO plan	In-network lab services copay	In-network hospital lab services using a nonparticipating lab copay	Out-of-network lab services copay
Essential	$0	$40	50% of approved amount
Vitality	$0	$40	40% of approved amount
Signature	$0	$30	40% of approved amount
Assure	$0	$20	30% of approved amount
Part B Credit	$0	$40	50%
+ Meijer	$0	$40	50%
Medicare Plus Blue PPO Group	Refer to the group's summary of benefits for cost-sharing information.		

When you, or other qualified members of your office staff, obtain laboratory specimens in your office, JVHL, LabCorp or Quest Diagnostics can arrange for a courier to pick up the specimen. If you prefer, direct your patients to have their laboratory specimens collected at participating lab patient service centers or 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 Blue Cross. Claims submitted directly to Blue Cross will not be reimbursed.

We also cover pathology services associated with the lab services provided by JVHL participating hospitals, LabCorp or Quest Diagnostics and the test specimens they send to an external reference laboratory.

In-network 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 the Medicare Plus Blue Physician Office Laboratory List (POLL). The procedures on the POLL are those that Blue Cross has determined to be appropriately provided in an office setting by in-network 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.
- Is medically necessary.

Note: Procedures performed in the office location that are not listed on Medicare Plus Blue POLL may not be reimbursed. The POLL is intended for use only by in-network providers. Blue Cross regularly reviews and periodically updates the POLL based on CMS guidelines.

Benefits

Overview

For basic Original Medicare benefits, refer to www.cms.gov.**

Medicare Plus Blue Individual PPO plan members will be assessed out-of-network cost sharing for non-urgent or emergency services received out of network. Out-of-network cost share will apply to a separate out-of-pocket maximum for out-of-network services. View summaries of benefits for Medicare Plus Blue PPO members here.

Primary care physicians

Blue Cross' Medicare Plus Blue PPO plan recognizes the following practitioner specialties as personal or primary care physicians:

Accepted Primary Care Providers		
Certified nurse practitioner – primary care focus	Family practice	General practice
Geriatrician	Internal medicine	Obstetrics and gynecology
Pediatric medicine	Physician assistant – primary care focus	

Note: Some plans have a higher copayment for specialists.

Hearing, dental and vision coverage

All individual Medicare Plus Blue PPO plan options offer coverage for hearing, vision and preventive and comprehensive dental services.

Individual Medicare Plus Blue PPO members have supplemental coverage for routine hearing exams, fitting and evaluation exams for hearing aids and hearing aids. Members receive the maximum level of coverage when they obtain services from a hearing provider who participates with Blue Cross' Medicare Advantage PPO network. If you have questions about the Medicare Plus Blue PPO hearing benefit, please call our Provider Inquiry department at **1-866-309-1719**.

Medicare Plus Blue individual members have coverage for preventive and comprehensive dental services (e.g., crowns and root canals). The benefit provides an annual maximum for combined in-network and out-of-network dental services per calendar year. To check patient benefit and eligibility information, visit the dental provider portal at provideraccess.dentaquest.com.**

The plans offer vision coverage administered by Vision Service Plan (VSP), recently rebranded as VSP Vision. When members obtain covered services from a VSP network provider, they receive the maximum level of coverage available under their plan. For information about VSP Vision, visit their provider hub at vspproviderhub.com.**

All individual Medicare Plus Blue PPO members have the option to elect additional coverage for dental (e.g., dentures, implants) and vision services through the purchase of an Optional Supplemental benefit package. Descriptions of the coverage offered in these packages are included in the members' Medicare Plus Blue PPO *Evidence of Coverage* document.

Fitness benefit

Medicare Plus Blue PPO plans offer a fitness benefit known as the SilverSneakers® Fitness Program. The Michigan Blue plans support physical fitness at any age and hope that you will encourage your Medicare Plus Blue patients to enroll in the program, which offers a complimentary membership to any participating location. SilverSneakers also offers digital and self-directed programs for members who want to exercise at home. More information about this fitness benefit is available online at silversneakers.com.**

Enhanced benefits

Medicare Plus Blue plans include enhanced benefits that cover benefits in addition to what Original Medicare covers. You can find those benefit policies on our website under Enhanced Benefits.

Note: Group coverage may not include the vision, hearing, preventive dental or fitness benefits described above.

The following group plans have enhanced benefits exclusive to the group, which are listed on the Enhanced Benefits webpage linked above.

City of Livonia

State Health Plan Medicare Advantage PPO

UAW Retiree Medical Benefits Trust

University of Michigan Medicare Plus Blue PPO

Virtual Care benefit

All Medicare Plus Blue members have a Virtual Care benefit. Virtual Care is available through Teladoc Health®, an independent company and our plan-approved vendor. To access this benefit, members should visit bcbsm.com/virtualcare. We encourage members to share Virtual Care visit summaries with their providers.

Note: This service is separate from any telehealth services that our contracted providers might offer. If you would like to offer telehealth services and have the technology to do so, you may bill us for these services as permissible within current CMS guidance.

Virtual Care through Teladoc provides urgent care and behavioral health care through a member's phone, tablet, or computer from anywhere in the United States. Virtual urgent care visits from U.S. board-certified doctors are available 24/7, without an appointment. Virtual behavioral health visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists.

For evaluation and management services provided by Virtual Care through Teladoc, we reimburse for procedure codes *99202, *99203, *99211, *99212 and *99213.

MPSERS member benefits

Ambulance treatment without transport

Members pay 10% of the of the BCBSM approved amount for ambulance services not requiring transportation. The annual deductible applies.

Fitness benefit

MPSERS members with Medicare Plus Blue plans can participate in the SilverSneakers® fitness program at no additional cost.

SilverSneakers is the nation's leading exercise program designed to keep older adults active and healthy. Health care providers should encourage their senior patients to consider participating in the SilverSneakers fitness program. For details, read the SilverSneakers article in the November 2021 issue of *The Record*. More information about this fitness benefit is available at silversneakers.com.**

Hearing services

Blue Cross provides routine hearing care benefits and hearing aids for MPSERS members exclusively through TruHearing, an independent company that provides hearing services. TruHearing doesn't provide Blue Cross-branded products or services, but our arrangement allows them to work with us to administer the MPSERS hearing care and hearing aids benefit.

Because TruHearing coordinates services directly between the member and provider, members won't have TruHearing ID cards.

MPSERS members hearing benefit highlights

- An audiometric hearing exam once every 36 months with a $45 copay. Must be performed by a TruHearing provider.
- One year of follow-up visits
- Up to two TruHearing Advanced hearing aids ($499 copayment per aid) or TruHearing Premium hearing aids ($799 copay per aid) every 36 months
- A 60-day trial with the purchase of each hearing aid
- A full three-year manufacturer's warranty
- 80 batteries per non-rechargeable hearing aid

Tips for providers

Routine hearing services and hearing aids are only covered for MPSERS members when they call TruHearing at 1-855-205-6305 and follow the directions provided.

Give MPSERS members the opportunity for a trial to give them the best opportunity to use the benefit. Members have access to a free online hearing test and more at truhearing.com/mpsers-hs.

Ask members who decide to waive their hearing benefit (whether it's their preference or a medical necessity) to complete a TruHearing Select Non-Covered Services form.

- Providers will need to submit these forms directly to TruHearing.
- Members who waive their benefits can then use the TruHearing Choice discount program, which includes 200-plus hearing aid models from five manufacturers.

Collect member hearing exam and full TruHearing hearing aid copayments through the TruHearing provider portal, Echo. TruHearing will remit the allowable amount for the exam to providers approximately 10 days after the exam copay has been collected in Echo.

Collect full TruHearing hearing aid copayments through Echo. TruHearing will remit the hearing aid professional fee to providers after the member's 60-day trial period.

Providers can get details about TruHearing hearing aids, provider spec sheets, a fitting guide, a reference guide and other information about the TruHearing product line here.** Training courses are also available to providers on Audiology online at www.audiologyonline.com.**

For more information about training or tools needed to ensure successful hearing aid fittings or partnering with TruHearing, providers should contact TruHearing Provider Outreach at 1-855-286-0550 or email Provider.outreach@truhearing.com.

Financing is available for MPSERS members through AllWell Financing, if interested.

Vision services

Medicare Advantage and commercial retirees with MPSERS coverage have vision benefits through EyeMed Vision Care.

EyeMed will mail new members a separate welcome kit detailing their vision benefits. The kit also includes the member's new EyeMed vision ID card.

Retirees who share a vision policy with a dependent or spouse will receive two identical ID cards with the retiree's name on it. Providers who wish to assist members with discussing their vision benefits or coverage can visit EyeMed's new dedicated website for MPSERS members, eyemed.com/mpsers.**

If providers have questions, they should contact EyeMed at **1-888-581-3648**.

UAW Retiree Medical Benefits Trust (URMBT) and University of Michigan Medicare Plus Blue PPO 5th Level Hospice benefit

Medicare Advantage URMBT and University of Michigan retirees are eligible for 5th Level Hospice coverage for inpatient room and board hospice care in a skilled nursing facility (SNF) or hospice facility. The benefit will be subject to the member's deductible and coinsurance for a lifetime maximum of 210 days of coverage for URMBT's plan and 45 days of coverage for University of Michigan's plan.

To read more about the URMBT and U of M 5th Level Hospice benefit, visit the Enhanced Benefits page of our website and click the link to the UAW, U of M Retiree Medical Benefits Trust 5th Level Hospice Care, PPO (PDF).

Hospice services

Overview

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. Claims for services provided to a Medicare Plus Blue PPO member who has elected hospice care should be billed to the appropriate Medicare contractor.

Claim submission

- If the member elects hospice care and the service is related to the member's terminal condition, submit the claim to the regional home health intermediary.
- If the member elects hospice care and 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.

  Note: Original Medicare is responsible for the entire month that the member is discharged from hospice.
- If the service is not covered under Original Medicare but offered as an enhanced benefit under the member's Medicare Plus Blue PPO plan (for example, vision), submit the claim to the local Blue plan.

Medicare Advantage member cost-share for hospice services

As provided in 42 CFR § 422.320, an MA organization must inform each enrollee eligible to select hospice care about the availability of hospice care if: (1) a Medicare hospice program is located within the plan's service area; or (2) it is common practice to refer patients to hospice programs outside the MAO's service area.

An MA enrollee who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive (through the MA plan) any MA benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the enrollee and the MAO, providers, and suppliers for other Medicare-covered services furnished to the enrollee.

The table below summarizes the cost-sharing and provider payments for services furnished to an MA plan enrollee who elects hospice.

Type of services	Enrollee coverage choice	Enrollee cost sharing	Payments to providers
Hospice program	Hospice program	Original Medicare cost sharing	Original Medicare
Non-hospice[1], Parts A & B	MA plan	MA plan cost-sharing, if enrollee follows MA plan rules[3]	Original Medicare[2]
	Original Medicare	Original Medicare cost-sharing, if enrollee does not follow MA plan rules[3]	Original Medicare
Non-hospice[1], Part D	MA plan (if applicable)	MA plan cost-sharing	MAO
Supplemental	MA plan	MA plan cost-sharing	MAO

[1]The term "hospice care" refers to Original Medicare items and services related to the terminal illness for which the enrollee entered the hospice. The term "non-hospice care" refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

[2]If the enrollee chooses to go to Original Medicare for non-hospice, Original Medicare services, and also follows plan requirements, then, as indicated, the enrollee pays plan cost-sharing and Original Medicare pays the provider. The MA plan must pay the provider the difference between Original Medicare cost-sharing and plan cost-sharing, if applicable.

[3]A Medicare Plus Blue member who receives services out-of-network and has followed plan rules is only responsible for plan cost-sharing. The member doesn't have to communicate to Blue Cross in advance regarding his or her choice of where services are obtained.

Access to care

Accessibility of services

Accessibility of services is measured by after-hours access and appointment access.

After-hours access

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

Practitioners must provide coverage for their practice 24 hours a day, seven days a week with a published after-hours telephone number (to a practitioner's home or other relevant location), pager or answering service, or a recorded message directing members to a physician for after-hours care instruction. Note: Recorded messages instructing members to obtain treatment via emergency room for conditions that are not life threatening are not acceptable.

In addition, primary care physicians must provide appropriate backup for absences.

Appointment access

Blue Cross follows standardized national guidelines and information from medical societies to guide clinical care in our decision-making processes. Blue Cross has established standards for primary, behavioral health and specialty care services to ensure timely appointment access to health care. Each practitioner must, at a minimum, meet the following appointment standards for all Medicare Plus Blue members. Appointment accessibility will be measured and monitored using the following standards for primary care and specialty care physicians.

Primary care providers		
Appointment type	**Definition**	**Standard**
Regular and routine care	Appointments for regular or routine care, including follow up for chronic conditions and preventive care, may include but are not limited to: • Follow-up appointments for chronic conditions and all screenings indicated in standardized, nationally recognized and evidence-based clinical practice guidelines • Follow-up appointments related to a problem-focused issue such as blood pressure monitoring	Within 30 business days of member's request
Care that's not urgent	Appointments for conditions that require medical attention may include but are not limited to: • Appointments for post-hospitalization follow up • Reassessment of patient started on new medication	Within 7 business days of member's request
Urgent medical care (acute, symptomatic)	Appointments for acute conditions that are not life threatening may include but are not limited to: • Fever over 101 degrees Fahrenheit over 24 hours • Persistent vomiting and mild persistent diarrhea	Immediately
Emergency care	Appointments for conditions that require immediate intervention to prevent death or serious injury may include but are not limited to: • Uncontrolled blood sugar for diabetes patients who are on medication • Increased shortness of breath in COPD or asthma patient who is not responding to treatment	Immediately

Specialists		
Appointment type	**Definition**	**Standard**
Regular and routine care	Appointments for regular or routine care, including follow up for chronic conditions and preventive care, may include but are not limited to: • Changes in EKG results • Pregnancy monitoring	Within 30 business days of member's request

Behavioral health		
Appointment type	**Definition**	**Standard**
Initial visit for routine behavioral health care	Visits for situations in which no acute danger is detected and the member's condition is not likely to worsen significantly. Examples: • Patient has a new onset of symptoms of anxiety or depression and is complaining of having racing thoughts, which is new for them. • Patient states, "I've been in a constant state of nervousness for the last few days." **Note:** Initial routine care appointments don't include follow-up care for an existing problem.	Within 10 business days of member's request
Follow-up visits for routine behavioral health care	Follow-up routine care appointments are visits at later, specified dates to evaluate the member's progress and other changes that have taken place since a previous visit. Examples: • Patient is taking a new medication and needs follow up, based on screening and triage, along with a longer-term plan of care and a monitoring protocol. • Patient states, "I have been taking lithium and I need my lab drawn per my primary care doctor's request."	Within 30 business days of member's request
Non-urgent behavioral health care	Appointments for conditions that are not urgent but that require medical attention. Examples: • Follow up after discharge from hospital or treatment facility • Symptoms of relapse of substance use disorder despite treatment	Within 7 business days of member's request

Behavioral health		
Appointment type	**Definition**	**Standard**
Urgent behavioral health care	Visits for conditions that are not life threatening, but for which face-to-face evaluation is necessary within a short period of time. Examples: • Inability to care for basic needs • Acute stress, such as from foreclosure or death of a loved one	Immediately
Emergency behavioral health care: Conditions that are not life threatening	Visits for conditions that require rapid intervention to prevent deterioration of the member's state of mind that, left untreated, could jeopardize the member's safety. Examples: • Worsened depression or anxiety symptoms • Reoccurrence of chronic psychotic or manic symptoms	Immediately
Emergency behavioral health care: life-threatening conditions	Visits for conditions that require immediate intervention to prevent death or serious harm to members or others. Examples: • Plan for suicide or homicide with access to means • Reoccurrence of severe post-traumatic stress disorder symptoms	Immediately

In-office waiting room times

Acceptable office waiting room time for all practitioners should be no more than 15 minutes from the scheduled time of appointment. Members should be advised of delays as soon as possible. If a delay occurs, the member should be advised of the estimated time at which the appointment will begin. If the member is unable to wait, an alternate appointment should be offered consistent with appointment access standards.

Compliance with access standards

The table below outlines what occurs when a provider does not meet standards for appointment access and access for after-hours care. Follow-up monitoring occurs within a time frame determined by the appropriate plan medical director. The time frame will not exceed 90 days.

If…	Then…
The practitioner does not meet compliance standards on the initial assessment	The provider is educated on the initial call or on a separate call from the BCBSM Quality Management department and then contacted within 14 days after the education to reassess compliance.

If…	Then…
The practitioner remains noncompliant	The BCBSM Quality Management department notifies the appropriate plan medical director and requests that a provider consultant reach out to the provider for further follow-up. The provider is asked to submit a corrective action plan to the Quality Management department within 30 days.
The practitioner's corrective action plan is approved	The provider is notified that the plan is approved and is reassessed for compliance within 14 days. The provider will be sent a letter with the results.
The corrective action plan is not approved	A request will be made that the practitioner submit an acceptable corrective action plan within 14 days.
A reply is not received within 14 days	The practitioner will be sent a reminder letter indicating that he or she must submit an acceptable corrective action plan within 14 days.
A reply to the reminder letter is not received within 14 days	Another letter is sent informing the provider that his or her contract will be terminated within 60 days. The BCBSM Quality Management department forwards copies of the letter to the appropriate plan medical director, the director over the BCBSM provider engagement team, and the director of the BCBSM Corporate Credentialing and Program Support department.

Blue Cross encourages Medicare Advantage PPO practitioners (or their office staff) to assist members whenever possible in finding an in-network practitioner who can provide necessary services. If assistance is needed in arranging for specialty care (in- or out-of-network), please call our Provider Inquiry department at **1-866-309-1719**.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

All providers rendering services and receiving payment from Blue Cross must also comply with Section 1557 and Section 504. They may not refuse to provide covered services to members based upon Blue Cross or BCN's payment level, benefit or reimbursement policies. In addition, providers may not discriminate against members on the basis of physical or mental disability.

Health care providers must provide covered services to Blue Cross and BCN members in the same manner as and with the same quality and promptness with which they provide services to patients with other health plans. Providers may not intentionally segregate members in any way or treat members in a manner or location different from other persons receiving health care services.

Advance Directives

Overview

Blue Cross provides Medicare Plus Blue PPO members information on their right to complete an advance directive. Advance directive means a written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law and signed by a patient, that explains the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known. As part of the medical record content requirements for Blue Cross Blue Shield of Michigan, physicians must document discussion in the medical record of whether a member has or does not have an advance directive. If a member has completed and presents an advance directive, then the provider must include it in the member's medical record.

Medical management and quality improvement

Care and disease management

Blue Cross has reimagined care management to deliver a truly holistic, member-centric approach to coordinated care delivery where it's needed most. The Blue Cross Coordinated Care program includes the use of enhanced analytics to identify and target the members who need it the most, and a multi-disciplinary care team to support their care needs.

For questions about our care management programs or if you feel your patient would benefit from one of our programs, call our Provider Inquiry department at **1-866-309-1719**. Care managers may contact you directly to coordinate care and services.

Blue Cross Coordinated Care program features include:

- Utilization of robust analytics and enhanced data sets allows Blue Cross to identify members who are at high risk and/or clinically complex based on observed conditions, utilization of services and other risk factors. Predictive analytics are also used to proactively identify members who are likely to experience an exacerbation of symptoms based on early indicators.
- Integrated care teams, led by a care manager, include nurses, social workers, behaviorists, pharmacists, physician consultants and dietitians

who focus on specific geographic regions to enable more community-centric care.

- App-based digital technology that connects members to relevant care information through the channel of their choice – digital chat or text.

Care planning process

The Blue Cross Coordinated Care member-centered, care management program supports members to make informed decisions and successfully manage their own health by being an active participant in the care planning process. Once the member assessment is complete, care managers will develop comprehensive care plans for each member including interventions, goals, barriers and measurable outcomes. The care plan will include medical, behavioral, and self-management goals to improve members' health outcomes. Care managers will ensure that the care goals reflect member, physician, caregiver and nurse input. Prioritization of the care goals will be individualized for each member utilizing evidence based clinical guidelines and motivational interviewing techniques. The care plan is supplemented by input from the multidisciplinary care team including nurses, pharmacists, social workers, behavioral health specialists and dietitians when applicable.

Coordination of services

One of the key tenants of the Blue Cross Coordinated Care program is to provide coordination of services to our members to reduce fragmentation. Coordination of services involves thoughtfully organizing the member's care activities and sharing information among all the participants concerned with that member's care to achieve safer and more effective outcomes.

The Blue Cross Coordinated Care program provides an integrated care team led by a care manager who serves as the single point of contact for members and their families. The care manager is responsible for the coordination of medical, social, and behavioral services for each member. This comprehensive care team works in tandem to manage the member's care. Furthermore, some care teams are regional to allow enhanced coordination with local providers and community resources and increased ability to address social determinants of health.

Through the care manager, members have access to the following disciplines:

- A nurse for clinical education, support and more
- A medical director when physician expertise is required
- Non-clinical support for care coordination and administrative tasks
- Pharmacy support
- Behavioral health support

- Dietician for nutrition education
- Social worker for support in obtaining community resources to address the social and environmental factors that determine health (transportation, food, etc.)

Discharge planning

Members in transition from inpatient to community settings who are at risk of exacerbation of symptoms may receive support through outreach from a member of the Blue Cross Coordinated Care team. The goal is to reduce the risk of readmission and to ensure a smooth and successful transition. Initiatives of this program include:

- Provide education on clinical warning signs
- Discuss and encourage adherence to treatment plan/discharge instructions
- Assist members in scheduling follow-up appointments with their treating physician
- Educate members on the importance of medication adherence
- Assess member's social determinants of health
- Assess member for behavioral health needs
- Connect members with treating providers, supplemental services and community resources

Coordination with physicians

The Blue Cross Coordinated Care program is designed to support providers in their efforts to deliver the best possible care for their patients. A multidisciplinary, integrated care team provides holistic care management to members designed to address their individual diverse health needs.

This team supports provider-delivered care by:

- Assisting members with scheduling medical appointments.
- Following up with members after doctor's appointments to reinforce the importance of adhering to treatment plans.
- Providing condition-specific education to members with chronic and complex care needs.
- Co-managing members participating in Provider-Delivered Care Management programs to support the prescribed treatment plan when applicable.

To support patient care, a member of the integrated care team may let the primary care doctor or specialist know if one of their patients is participating in the care management program. The program isn't intended to replace

the doctor-patient relationship in any way, but rather to support the member with following their physician and care teams recommendations to improve their health.

Palliative Care

Blue Cross contracted with Carelon Health, previously called Aspire Health, to provide members with non-hospice, palliative care that focuses on symptom management, patient-family communication, advance care planning, medical crisis prevention and urgent response. Aspire Health's name changed to Carelon Health effective Jan. 1, 2024. Only the name has changed, not the benefit.

Comprehensive, collaborative care is delivered by community-based providers to members with a life expectancy of less than 12 months and consists of medical care provided by a multidisciplinary team that includes a palliative care physician, nurse practitioner, social worker, patient care coordinator, registered nurse and chaplain.

Palliative care is available to members residing in select ZIP codes within geographic areas including Alabama, Indiana, Kansas, Michigan, Missouri, North Carolina, Ohio, Tennessee and a limited number of ZIP codes in Florida.

A telehealth palliative care program is available to some rural regions in Michigan, including Northern Michigan, the Thumb area and the Upper Peninsula, that lack the population density to support home-based services.

Provider-Delivered Care Management

The Provider-Delivered Care Management program is a comprehensive array of patient education, coordination and other support services delivered face-to-face and over the telephone by ancillary health care professionals who work collaboratively with the patient, the patient's family, and the patient's primary physician. PDCM is integrated into the clinical practice setting and builds upon the patient-centered medical home model in transforming health care delivery, enabling providers to deliver coordinated team-based care. These professionals perform PDCM services within the context of an individualized care plan designed to help patients with chronic and complex care issues address medical, behavioral, and psychosocial needs. PDCM helps patients meet personal health care goals that contribute to optimal health outcomes and lower health care costs.

Program goals include improved outcomes such as lower emergency department use, fewer inpatient stays and consistent delivery of recommended services, such as cancer screening, hypertension monitoring support and diabetes management programs.

Psychiatric Collaborative Care Model (CoCM)

CoCM is a model of behavioral health integration that enhances "usual" primary care by adding two key services to the treating provider team,

particularly for those patients whose conditions are not improving:

- Behavioral health care management support for patients receiving CoCM treatment
- Regular case reviews of CoCM patients by the behavioral health care manager and the consulting psychiatrist

The CoCM treating provider team consists of three individuals: the treating (billing) practitioner, the behavioral health care manager and the psychiatric consultant.

Current Procedural Terminology, or CPT®, codes *99492, *99493, *99494 and HCPCS code G2214 are used to bill for monthly services furnished using the Psychiatric Collaborative Care Model (CoCM). CPT code *99484 is used to bill monthly services furnished using BHI models of care other than CoCM.

When an FQHC is delivering care to a Medicare Advantage member, the code G0512 is used to bill for monthly services. G0511 is used to bill monthly services using BHI models of care other than CoCM.

All *CoCM services are covered under the member's medical care*, rather than behavioral health care. No prior authorization is required for CoCM services.

Tobacco Cessation Coaching

For 2025, we have a new Tobacco Cessation Coaching program vendor: Personify Health (powered by Virgin Pulse). It's a telephone-based program designed to support members in their efforts to stop smoking. The program's goal is to improve the members' quality of life as well as reduce costs and hospital utilization for conditions associated with tobacco use. Members can call Personify Health at 1-833-380-8436 to enroll and schedule their first call. TTY users, call 711.

24-Hour Nurse Advice Line

The 24-Hour Nurse Advice Line is a 24/7 telephone triage and health information service. Nurses maintain client confidentiality while providing support, symptom and if necessary, referring members to appropriate sources for further information. Nurses also provide support on symptom management, provider searches, clinical support, education and referral to community resources. Members can contact a nurse via the 24-Hour Nurse Advice Line by calling 1-855-624-5214.

Health and Wellness

Our health promotion and wellness programs give 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 bcbsm.com/medicare and click on the Resources tab.

Information obtained is used to support continuity of care through care management program identification and Blue Cross program development.

Landmark Health in-home care program phasing out by March 31, 2026.

High-intensity in-home care program by Landmark Health

Blue Cross, BCN and Landmark MSO, LLC, have mutually agreed to discontinue our relationship by March 31, 2026. We'll work together to transition members receiving Landmark high-intensity in-home care services to alternate programs and resources by that date. As of October 1, 2024, Landmark is no longer actively engaging with new members. Members who have already engaged in the program will be disenrolled in phases, beginning with those members who have the lowest level of engagement and who are the most clinically stable. We expect that the volume of engaged members will decrease throughout 2025 as members are disenrolled.

Our top priority during this transition is to ensure that Medicare Plus Blue members who have engaged with Landmark continue to be supported. We're committed to ensuring these members have access to plan led and provider-based programs and resources that will help to manage their conditions, as these members are among our most frail.

Care navigation services through Homeward Health

Blue Cross and BCN are working with Homeward Health to expand access to care for Medicare Plus Blue and BCN Advantage members in Michigan's Upper Peninsula and in the northern Lower Peninsula.

Homeward's services supplement the services provided by primary care providers to improve patients' health, while focusing on health care provider collaboration and communication.

For additional information about the Homeward program, see the document titled Home-based services: For chronic condition monitoring, in-home medical services, prior authorization determinations and more.

Quality improvement program

Blue Cross Blue Shield of Michigan is committed to improving the quality of health care for our Medicare Advantage PPO members. Medicare Plus Blue PPO maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services members receive and routinely measure the results to ensure members are satisfied and expectations are met.

The Medicare Plus Blue PPO Quality Improvement unit develops an annual quality improvement program that includes specific quality improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Member satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Quality improvement projects
- Healthcare Effectiveness Data and Information Set (HEDIS®)***
- Consumer Assessment of Healthcare Provider and Systems Survey and Health Outcomes Survey
- Regulatory compliance

***HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

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. Medicare Plus Blue PPO follows HEDIS reporting requirements established by the National Committee for Quality Assurance and CMS. Audited HEDIS reports will be used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures that Medicare Plus Blue PPO focuses on include:

- Acute hospital utilization
- Adherence to antipsychotic medications for individuals with schizophrenia
- Adult immunization status
- Blood pressure control for patients with diabetes
- Breast cancer screening (women 50–74 years of age)
- Cardiac rehabilitation
- Colorectal cancer screening (members 40–74 years of age)
- Controlling high blood pressure
- Depression screening and follow-up adolescents and adults
- Emergency department utilization
- Eye exam for patients with diabetes
- Fall risk management

- Follow-up after emergency department visit for substance abuse (within seven and 30 days)
- Follow-up after emergency department visit for mental illness (within seven and 30 days)
- Follow-up after emergency department visit for people with high-risk multiple chronic conditions (within seven days)
- Follow-up after hospitalization for mental illness (within seven and 30 days)
- Glycemic status assessment for patients with diabetes
- Hospitalization following discharge from a skilled nursing facility
- Hospitalization for potentially preventable complications
- Initiation and engagement of substance use disorder treatment
- Kidney health evaluation for patients with diabetes
- Management of urinary incontinence in older adults
- Medical assistance with smoking and tobacco use cessation
- Non-recommended PSA-based screening in older men
- Osteoporosis screening in older women
- Osteoporosis management in women who had a fracture (women aged 67–85)
- Persistence of beta-blocker treatment after a heart attack
- Pharmacotherapy for opioid use disorder
- Pharmacotherapy management of COPD exacerbation
    - Systemic corticosteroid
    - Bronchodilator
- Physical activity in older adults
- Plan all-cause readmissions
- Potentially harmful drug-disease interactions in older adults
- Social need screening and intervention
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Transition of care
    - Notification of inpatient admission

  - Receipt of discharge information
  - Patient engagement
  - Medication reconciliation post-discharge
- Use of high-risk medications in older adults
- Use of opioids at high dosage
- Use of opioids from multiple providers

CMS Star Ratings program

CMS evaluates Medicare Advantage health plans and issues Star Ratings each year.

The CMS plan rating uses quality measurements that are widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services Blue Cross offers. CMS compiles its overall score for quality of services based on measures such as:

- How Blue Cross helps members stay healthy through preventive screenings, tests and vaccines and how often our members receive preventive services to help them stay healthy.
- How Blue Cross helps members manage chronic conditions
- How well Blue Cross helps members maintain or improve their mental and physical health
- Member satisfaction with Blue Cross and their experience with their provider
- How often members filed a complaint against Blue Cross
- How well Blue Cross handles calls from members

In addition, because Blue Cross offers prescription drug coverage, CMS also evaluates Blue Cross prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

Find more information at the links below:

- Star Ratings program - Fact Sheet - 2025 Medicare Advantage and Part D Star Ratings**
- HOS - hosonline.org/en/**

- CAHPS - ma-pdpcahps.org/**
- HEDIS - ncqa.org/hedis/**

Blue Cross Medicare Advantage tool, Health e-Blue

Health e-Blue℠ is a clinical support tool that helps track members' health and offers Medicare Plus Blue providers consistent and timely data like health registry, utilization and pharmacy information.

We routinely request certain data from providers. With Health e-Blue, providers have the convenience of entering patient services and lab codes. They are also able to view vaccination information online as well.

Blue Cross partners with our Medicare Plus Blue providers by identifying their Medicare Advantage patients who need specific medical services so providers can contact those patients and schedule necessary services. Health e-Blue helps physicians identify gaps in care and receive information about their patients through enhanced encounter facilitation. Health e-Blue is designed to enable providers to get the information on patients for necessary services (such as mammograms) and helps them to take action toward providing those services.

The following provider specialties can register for our Medicare Advantage Health e-Blue:

Health e-Blue provider specialties		
Addiction Medicine – Family Practice	Geriatric Medicine – Internal Medicine	Pediatric Infectious Disease
Addiction Medicine	General Practice	Pediatric Gastroenterology
Adolescent Medicine	Hematology – Internal Medicine	Pediatric Hematology/Oncology
Adolescent Medicine – Pediatrics	Hematology/Oncology	Pediatric Nephrology
Allergy/Immunology	Interventional Cardiology	Pediatric Pulmonology
Allergy/Immunology – Internal Medicine	Infectious Disease	Pediatric Rheumatology
Cardiology	Internal Medicine	Preventive Medicine
Critical Care Medicine	Internal Medicine Pediatrics	Public Health / General Preventive Medicine
Critical Care Medicine – Internal Medicine	Nephrology	Pulmonary Disease
Critical Care Medicine – Pediatrics	Neuromusculoskeletal Medicine	Rheumatology

Health e-Blue provider specialties		
Cardiovascular Disease	Oncology	Sports Medicine – Family Practice
Endocrinology, Diabetes / Metabolism	Pediatrics	Sports Medicine – Internal Medicine
Family Practice	Pediatric Allergy/Immunology	Sports Medicine – Pediatric
Gastroenterology	Pediatric Cardiology	
Geriatric Medicine – Family Practice	Pediatric Endocrinology	

How do providers sign up?

Because Health e-Blue is a web-based tool, providers will need access to our provider portal on Availity Essentials to register for Health e-Blue. First, your organization's Availity Essentials administrator must add you as a Health e-Blue user through Availity Essentials.

To register for Health e-Blue, complete **both** the Health e-Blue Application and the Use and Protection Agreement to access Health e-Blue.

This documentation will ensure that Medicare Advantage member-protected health information is shared only with the appropriate providers. Note: If you have current Health e-Blue access through Blue Care Network, you do not have to complete another Health e-Blue Application and Use and Protection Agreement to access Blue Cross Health e-Blue.

It's important that providers complete all fields on the Health e-Blue Application and the Use and Protection Agreement by providing name, office name, details, state license number and proper, authorized signature. Otherwise, the forms will be returned for completion and access will be delayed.

Provider Performance Recognition Program

The Provider Performance Recognition Program was developed to reward our Medicare Plus Blue providers for encouraging patients to get preventive screenings and procedures (such as colonoscopies), and for achieving certain disease management measures such as HbA1c control.

Both BCN and Medicare Plus Blue providers are eligible to participate in the Provider Performance Recognition program. The program rewards their primary care physicians for performance measures that come from HEDIS, established by the National Committee for Quality Assurance. Measures are primarily focused on preventive care and chronic conditions.

Providers can use Health e-Blue to identify patients' treatment opportunities for HEDIS and Provider Performance Recognition Program

measures. If you have questions about how to do this, contact your provider consultant.

Medication Therapy Management program

Eligibility

To be eligible for participation in a Medication Therapy Management, or MTM, program, a member must meet at least one of the two conditions below:

- Be an at-risk beneficiary as defined by the Blue Cross internal drug management program
- Meet all of the following criteria:
  - Have at least three core chronic medical conditions such as Alzheimer's disease, congestive heart failure, respiratory disease (such as COPD or asthma), diabetes, HIV/AIDS, hypertension, high cholesterol, end-stage renal disease, mental health disorders (such as depression, schizophrenia or bipolar disorder) or bone disease (such as rheumatoid arthritis, osteoporosis or osteoarthritis)
  - Be on at least eight Part D maintenance medications
  - Be reasonably expected to incur $1,623 worth of drug expenses in one calendar year

Services

Our pharmacy benefit manager administers the MTM program. This program utilizes a team of providers including pharmacists and pharmacy interns to perform member outreach. All new members eligible for the MTM program receive a welcome packet in the mail that explains the program details and invites the member to complete a Comprehensive Medication Review. The CMR is an interactive consultation conducted between the member or the member's representative and a pharmacist or pharmacy intern once the member is enrolled in the program. The CMR generally lasts approximately 30 minutes and reviews every medication the patient takes (including prescription, over-the-counter products, supplements, herbals, physician samples) for potential drug interactions, adherence problems, low-cost alternatives, etc. The pharmacist or pharmacy intern asks open-ended questions to ensure patients understand their personal medication regimen.

The patient is mailed a written summary of the CMR within 14 days, with a complete updated medication list and an explanation of any medication issues that were discussed. If any serious issues were identified during the CMR, the pharmacist or pharmacy intern will contact the member's prescriber by phone and/or fax to address these issues. Per CMS, everyone who is eligible for the MTM program must be offered a CMR at

least once a year. In addition to the mailing, identified members may be called by the MTM team to encourage their participation.

Per CMS, all MTM program-eligible members must also receive a targeted medication review at least once every quarter. This is a clinical review of a member's claims by a pharmacist and/or an automated process by the MTM software. If any serious drug-related problems are identified, the prescriber will be contacted via secured fax or telephone to address the finding and suggest possible recommendations to resolve the issue.

Medicare Diabetes Prevention Program

Overview

Your patients with Medicare Part B coverage who are at risk for Type 2 diabetes may be eligible for the Medicare Diabetes Prevention Program (MDPP). It's offered at no cost to the member. This is a once-per-lifetime benefit available for up to one year. CMS is allowing members to receive MDPP services through distance learning through Dec. 31, 2027.

In a random controlled trial, the National Institutes of Health proved the program greatly reduces the progression of prediabetes to Type 2 diabetes. Program services are delivered by lifestyle coaches in community settings. The coaches are trained by organizations that are certified by the Centers for Disease Control and Prevention.

Criteria

Medicare criteria for MDPP eligibility are:

- Enrollment in Medicare Part B
- Blood value (one of the following):
  - Fasting plasma glucose of 110-125 mg/dl
  - Hemoglobin A1c value between 5.7 and 6.4
  - Oral glucose tolerance test between 140 and 199 mg/dL
- Body mass index greater than 25 (if Asian, greater than 23)
- No diagnosis of end-stage renal disease, Type 1 or Type 2 diabetes; previous gestational diabetes isn't an exclusion to participation.

Medicare beneficiaries with certain risk factors for pre-diabetes will need a glucose test within the last 12 months to confirm they meet the criteria. The following tests can be ordered with no copays or deductibles:

- CPT *82947 Glucose; quantitative, blood (except reagent strip)
- CPT *82950 Glucose; post glucose dose (includes glucose)
- CPT *82951 Glucose; tolerance test (GTT), 3 specimens (includes glucose)

Blue Cross is no longer working with Solera Health to process new enrollments into MDPP classes. However, MDPP certified providers listed below are offering classes and can bill Blue Cross directly for MDPP services:

District Health Department #10 – covers the counties of Newaygo, Mecosta, Manistee, Oceana, Crawford, Wexford, Lake, Missaukee, Kalkaska and Mason

Email address: preventdiabetes@dhd10.org
Phone number: 231-465-1934
Website: livewell4health.org/diabetes-prevention

Trinity Health – multiple in-person locations

Email address: diabetesprevention@trinity-health.org
Phone number: 734-655-8952
Website: trinityhealthmichigan.org/diabetesprevention

Henry Ford Health – multiple in-person locations

Email address: hfhsdpp@hfhs.org
Phone number: 313-876-8300
Website: henryford.com/services/diabetes/treatments/prediabetes

For more information on the MDPP and to help your patients find MDPP-certified providers in their area, please visit the Medicare.gov MDPP Basics webpage.**

Pharmacy treatment improvement opportunities

Overview

In addition to our formularies, prescribing limits and restrictions, we promote quality of care by monitoring claims to improve outcomes and patient safety. CMS requires us to identify certain treatment opportunities and proactively address them with providers and members. Some of these medication issues factor into our Star rating scores.

Medication adherence

We pay close attention to medication adherence for disease states such as diabetes, hypertension and hypercholesterolemia. We monitor medication adherence rates by reviewing pharmacy claims data, and if a member is non-adherent to their medications, we will address this with the member to see why the member is not taking his/her medication as prescribed.

Statin use in diabetes

The guidelines of several medical societies state that people with diabetes should be on a statin, regardless of whether they have high cholesterol or not, in order to prevent cardiac events such as heart attacks. We will alert prescribers when they have members with diabetes that are not on a statin.

Use of multiple anticholinergic medications

The common side effects of anticholinergic drugs include dry eyes, xerostomia, constipation and urinary retention. The use of multiple anticholinergics has also been associated with a greater risk of cognitive decline and dementia. These adverse effects can be especially harmful in people ages 65 and over. Because of the safety risks of these drugs to our Medicare population, we will alert providers of anticholinergic polypharmacy use and encourage safer alternatives.

Opioid overutilization and concurrent use with benzodiazepines

Because of the risks involved with using frequently abused drugs (FADs) — defined as opioids and /or benzodiazepines — both Blue Cross and CMS urge physicians to prescribe FADs with caution and carefully monitor patients using these medications. CMS requires Blue Cross to actively monitor claims data for potential FAD overuse. If our analysis suggests potential overuse, we send a letter to the prescriber detailing our concerns and ask them to complete and return a questionnaire about the patient's condition and treatments. If the physicians verify that the current FAD therapy is medically necessary, safe, and appropriate for their patient, we'll follow up and report our findings to CMS. If we identify concurrent opioid and benzodiazepine use, we'll address this with the provider to see if there are safer alternatives.

If the physicians fail to respond to our request for information or agree that the current FAD therapy is not appropriate, Blue Cross may stop or limit coverage for the patient's opioid and/or benzodiazepine medication or implement a prescriber or pharmacy lock-in. We'll then notify the member and prescribers and report our findings to CMS.

Our analysis looks at:

- Safety risks, such as concurrent opioid and benzodiazepine use or instances when a patient receives a daily dosage of opioids — either from a single prescription, or multiple prescriptions — that's higher than established safety levels.
- Instances when a patient has been identified as having a potential opioid-related overdose, and has received an opioid prescription.
- High utilization patterns, where a patient may have FAD prescriptions from multiple physicians within the same time period.
- Potential fraud, waste or abuse, and when a patient visits multiple physicians to expand their access to FADs, a practice known as "doctor shopping."

Plans are required to implement a point-of-sale (POS) safety edit on the opioid drugs identified in the list below for a daily cumulative Morphine Milligram Equivalent (MME).

Opioid medications [a, b]		
benzhydrocodone	hydrocodone	opium

Opioid medications [a, b]		
buprenorphine	hydromorphone	oxycodone
butorphanol	levorphanol	oxymorphone
codeine	meperidine	pentazocine
dihydrocodeine	methadone	tapentadol
fentanyl	morphine	tramadol

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sublingual sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (i.e., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

Point-of-sale edit

The morphine milligram equivalent threshold identifies and places a stop to a claim at the point of sale (POS) that causes the daily MME to exceed 200 mg. This daily cumulative MME is calculated using a patient look-back on opioid claims within the pharmacy claims adjudication system. Using the calculation methodology, any particular claim exceeding the 200 mg MME threshold level could be stopped at the POS for clinical review.

The edit can be resolved by the submission of a prior authorization (PA) request by the prescriber or their delegate. Please keep in mind that the physician prescribing the dose that results in the member exceeding the daily threshold will be the same physician that will be required to resolve the PA requirement.

Documentation of medical necessity and acknowledgement of the significant clinical circumstance must be submitted for clinical review. The physician must demonstrate that the warranted amount of the opioid medication prescribed is needed to adequately manage the patients' pain while being safe and appropriate.

Daily morphine milligram equivalent conversion factor update

Please note: As of Jan. 1, 2024, CMS will use updated daily morphine milligram equivalent (MME) conversion factors to align with the CDC Clinical Practice Guideline for Prescribing Opioids for Pain. These updates will apply to all hydromorphone, methadone, and tramadol prescriptions.

Because of these changes, patients who are filling hydromorphone, methadone, or tramadol prescriptions may experience a claim rejection, because the member's total daily MME now exceeds the plan threshold level, even if the patient has not actually changed doses.

Current opioid safety edits:

- Initial fills for treatment of acute pain are limited to no more than a seven-day supply for opioid-naive members (members who have not filled an opioid prescription in the preceding 120 days). This includes short- and long-acting opioids, except for buprenorphine and other medication-assisted treatment products, which do not trigger an edit.
    - Any particular claim exceeding a seven-day supply for an opioid-naive member will be stopped at the POS for clinical review. In these instances, it is generally expected that either:
        - The beneficiary will receive an initial fill for a seven-day supply. Upon reassessment by the prescriber, if the beneficiary needs additional acute pain treatment, the prescriber will write another opioid prescription. The opioid-naive edit would not trigger; OR
        - The beneficiary will not receive any medication and instead will request a coverage determination from the plan for the full amount as written.
- Pharmacists must consult the prescriber and document the discussion when a member's cumulative morphine milligram equivalent reaches or exceeds 90 MME for all opioid prescriptions written for the member by all providers over the previous 120 days. If the prescriber confirms the intent, the pharmacist can use an override code that indicates the prescriber has been consulted.
- New CMS opioid safety edits alert pharmacists about a member's duplicative long-acting opioid therapy and concurrent use of opioids and benzodiazepines. The pharmacist can use an override code once the safety edits are reviewed.

Nonopioid directive

A nonopioid directive form** indicates to health professionals and emergency medical services personnel that an individual who has executed the form must not be administered an opioid or offered a prescription for an opioid. If a member or the member's patient advocate has completed and presents a nonopioid directive to a provider, then the provider must include a copy of it in the member's medical record.

We've posted the form on our website in response to a Michigan law.** Patients can log in to their online member account at bcbsm.com, click on *Forms* and then scroll to *Directives* to find the form. We've also put a link to the form on our member-facing Health and Well-Being page, under the Opioid Use Disorder box.

Immunization

Part B versus Part D

Medicare Part B and Part D both cover immunizations. Although the delineation of coverage is fairly clear, there are some exceptions where a vaccine could be covered under either plan.

When billing for prophylactic immunizations, the following always applies:

- Influenza, pneumonia and COVID-19 immunizations are always paid under Part B.
  (These are never covered under Part D.)
- Shingles and RSV immunizations are always paid under Part D.
  (These are never covered under Part B.)

Part B covers two categories of immunizations (prophylactic and injury/disease-related), and the benefit pays all charges associated with the vaccination in a single claim, including ingredient cost, dispensing fee, and injection or administration fee. Medicare will pay for immunizations in various venues: at a pharmacy, a clinic or a physician's office.

Activities associated with administering Part D vaccinations are also bundled into a single claim. However, incidental activity, such as an office visit, may involve additional cost-share to the patient.

Type of immunization	Part A covers	Part B covers	Part D covers
Prophylactic immunizations associated with a senior population: • Seasonal influenza • Pneumococcal pneumonia • Hepatitis B • COVID-19 (and booster)	Not applicable.	Immunizations for flu, pneumonia, COVID-19 (and booster) and hepatitis B for patients at high or intermediate risk of contracting the disease.	Hepatitis B vaccine may be covered if the patient does not meet Medicare's Part B criteria.
Vaccines administered by a health care provider for treatment of an injury, or as a result of direct exposure to a disease or condition.	Covers vaccines administered during an inpatient stay.	Covers limited vaccines administered on an outpatient basis. Some vaccines subject to review of clinical criteria to determine Part B or Part D coverage.	Covers RSV, shingles and other Part D vaccinations. Some vaccines (other than shingles) subject to review of clinical criteria to determine Part B or Part D coverage.
Note: Although shingles vaccinations are a prophylactic measure, these vaccinations are always covered under Part D. There is no coverage for this vaccination under Part B.			

Medicare Part B covers COVID-19 and flu shots in full and some organizations provide the flu shot free of charge while others may charge for a flu shot. It's important to remind these patients that Medicare Part B covers annual flu shots and COVID-19 vaccines at 100 percent (no copay or deductible). The claims must be submitted under Part B because flu, COVID-19 and pneumonia vaccinations are never paid under Part D.

Members are able to receive their Part B flu, COVID-19 and pneumonia vaccines at any participating network pharmacy (where vaccines are available) at no cost under their Medicare Plus Blue PPO Part B vaccine coverage. Please remind patients to use their current Medicare Plus Blue ID card to obtain these Part B vaccinations.

The following billing information should be submitted at the point of sale to adjudicate these claims:

PPO Plan	BIN	PCN	RxGroup
MA only	262400	RXBCMA	BCBSMAO BCBSMO1
MAPD	610011	CTRXMEDD	BCBSMAN BCBSMAN2
URMBT	610011	CTRXMEDD	BCBSMAN

Billing guidelines for roster bills

Providers who are mass immunizers, and/or providers who chose to bill using the roster billing method, must submit immunization claims on a roster bill and accept assignment under Original Medicare on both the administration and vaccine. Physicians and other health care providers enrolled in the Medicare program should follow the billing guidelines below when submitting roster bills to Blue Cross Blue Shield of Michigan:

- At this time, Blue Cross can only accommodate roster billing on paper claims.
- Providers may submit up to three rosters on a single CMS-1500 claim form for each type of vaccination.
- Rosters may include information regarding multiple patients.
- Typed rosters are preferred. If it is not typed, the roster information must be in blue or black ink and legible.
- Do not fold your claim or roster forms.

Mail your CMS-1500 claims and attached roster bills to the following address:

Medicare Plus Blue — Roster Billing
Blue Cross Blue Shield of Michigan

600 E. Lafayette Blvd.
P.O. Box 32593
Detroit, MI 48232-0593

Pharmacy – Point-of-Sale Part B Drugs

Overview

Pharmacies can bill Medicare Plus Blue plans directly for certain drugs approved for coverage under the Medicare Part B benefit, including nebulizer solutions, select oral cancer medications, immunosuppressants and select diabetic supplies. Existing cost sharing for these drugs per the member's plan still applies. Diabetic supplies will continue to be covered at 100%.

Note: This point of sale program is only for members with medical coverage through a Medicare Plus Blue plan.

Continuous glucose monitor products (CGM)

For dates of service on or after Oct. 1, 2024, Medicare Plus Blue members must obtain their continuous glucose monitor products through a participating network pharmacy.

Blue Cross Blue Shield of Michigan no longer covers CGM products dispensed by contracted or noncontracted DME suppliers for Medicare Plus Blue members.

Exception: UAW Retiree Medical Benefits Trust members are excluded from this change. These members should continue to obtain their CGM products through a DME supplier.

For more information, refer to the CGM products FAQ for prescribing providers.

Adjudication

The table below lists the medication types, and the benefit under which they will adjudicate.

Drug/equipment type	Current process	Medicare Advantage plans included
Nebulizer solutions	Will automatically adjudicate under Part B if member lives at home, under Part D if member resides in a long-term care or skilled nursing facility	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used[1]

Drug/equipment type	Current process	Medicare Advantage plans included
Select oral cancer medications	Will adjudicate under Part B; no prior authorization required	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used
Immunosuppressants	Will adjudicate under the correct benefit once a Part B versus Part D coverage review is complete	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used
Antiemetics	Will adjudicate under the correct benefit once a Part B versus Part D coverage review is complete	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used
Continuous glucose monitor products and supplies **FreeStyle Libre and Dexcom are preferred brands only**	As of Oct. 1, 2024, only available when dispensed by a network pharmacy. Not covered if obtained from a DME supplier. Member must have history of insulin use within the last 365 days. URMBT members **must** utilize a DME provider	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used URMBT members are excluded and **must** utilize a DME provider.
Diabetes testing supplies **OneTouch® only** Members are not limited to a specific brand when dispensed through a DME provider.	Is available when dispensed by a network pharmacy URMBT members **must** utilize a DME provider.	Medicare Plus Blue plans with or without prescription coverage if Blue Cross ID card is used

[1]For long-term care or skilled nursing facility residents without a Medicare Plus Blue prescription drug plan, pharmacies should bill using the member's Part D plan ID card.

Pharmacy – Part D Drugs

Medicare Prescription Payment Program

Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage Plan with drug coverage) can choose a payment option to help manage their out-of-pocket Medicare Part D drug costs by spreading them throughout the calendar year. Participation is voluntary and members won't pay any interest or fees on the amount owed, even if a payment is late.

Members will receive M3P election participation request form with their annual enrollment materials. To participate, members can opt-in online, contact Blue Cross by phone, or send a completed form to Blue Cross by mail. Members who have high drug costs are most likely to benefit from this plan. The plan doesn't lower their drug costs but will help them manage their monthly expenses.

Members who select this payment option will get a bill from Blue Cross to pay for their prescription drugs instead of paying the pharmacy. The member's payments might change every month, so they might not know what their exact bill will be ahead of time. Future payments might increase when a new prescription is filled because, as new out-of-pocket costs get added to the monthly payment, there are fewer months left in the year to spread out the remaining payments.

Network performance management

Radiology-focused quality improvement program – Covera Health

Blue Cross Blue Shield of Michigan contracted with Covera Health, an independent company, to help improve diagnostic quality related to radiology. The program helps radiologists and radiology facilities to:

- Engage in continuous quality improvement
- Identify peer-learning opportunities
- Improve patients' quality of care and outcomes

The program began June 12, 2023. As part of this program, radiologists and radiology facilities can register with Covera Health and be eligible to receive a high-quality designation. Providers will still need to request prior authorization for certain radiology procedures from Carelon Medical Benefits Management (formerly AIM Specialty Health). On approved prior authorization requests, facilities and radiologists with a Covera high-quality designation will display as recommended providers.

Participation in this program is voluntary and available to all radiology providers and facilities. Neither reimbursement nor value-based arrangements are affected if a practice or radiologist chooses not to participate in Covera's quality improvement program.

For more information on this initiative, refer to the January 2023 article in *The Record.*

Outpatient PT, OT, ST physical medicine and chiropractic services management

As of Nov. 1, 2024, Blue Cross Blue Shield of Michigan monitors network performance for PT, OT, ST, physical medicine and chiropractic services, a service previously performed by SecureCare, an independent company. Blue Cross directly conducts network performance reviews.

This applies to network performance management for the following outpatient services for Blue Cross commercial and Medicare Plus Blue members:

- Physical, occupational and speech therapy services provided by therapists
- Physical medicine services performed by chiropractors and athletic trainers
- Chiropractic services

Utilization management

Overview

Blue Cross has developed processes and guidelines for providers to proactively communicate and obtain authorization or certification for

anticipated services or admissions. In addition to providing a means of determining whether the patient's symptoms meet criteria for the level of care you've planned, authorization requirements provide Blue Cross with the information needed to identify members that may benefit from the assistance of one of our care management programs.

All medical procedures are subject to Blue Cross' claim processing rules and post-payment audits. Providers risk possible recovery of funds by Blue Cross during post-payment audits if clinical criteria are not met or if documentation is not maintained in the patient's medical records in accordance with CMS and Blue Cross specifications as outlined in the *Medical record audits and reviews* section of this manual.

The information below outlines the program guidelines for prescription drugs and specialty services such as high-tech radiology, cardiology, radiation oncology, spinal fusion, outpatient interventional pain management, behavioral health services, and inpatient admissions to acute care hospitals, prior authorization of other medical/surgical services, long-term acute care and inpatient rehabilitation facilities, and skilled nursing facilities. For more information regarding Medicare Advantage prior authorization, click here.

Continuity of care

CMS expanded their continuity of care guidelines to include members who are new to our Medicare Plus Blue plans and those who moved from a BCN Advantage plan to a Medicare Plus Blue plan. Members who meet the definition of a continuing care patient can continue treatment with their current provider for up to the first 90 calendar days after enrollment.

For members to continue with an existing course of treatment:

- Blue Cross must confirm that the member is in an active course of treatment when they join one of our Medicare Plus Blue plans or when they move from a BCN Advantage plan to a Medicare Plus Blue plan.
- Providers must document the member's course of treatment or treatment plan in the member's medical record. The documentation must show the services planned for the member.
- Providers who submit a request for prior authorization may be asked to confirm the member is undergoing an active course of treatment.
- Blue Cross may ask for the member's treatment plan to use in reviewing the prior authorization request.

Prior authorization of prescription drugs covered under the pharmacy

To help ensure our members receive high-quality, cost-effective pharmaceutical care, we require prior authorization for certain medications and clinical criteria must be met before the request for authorization is approved. Clinical criteria are based on current medical information and the recommendations of the Blue Cross / BCN Pharmacy and Therapeutics Committee. Drugs that are subject to step therapy may require previous treatment with one or more formulary agents prior to coverage. You can view our formularies online here to find out if a

benefit – Medicare Part D

medication is covered by our plan and what drugs require prior authorization or step therapy.

Note: See the "Oncology Value Management program" below for information about oncology pharmacy benefit drugs.

To request prior authorization, you can call, fax, mail or submit requests via an electronic prior authorization, or ePA, tool. ePA is the preferred method. You can use CoverMyMeds®** and other free ePA tools such as Surescripts®** to submit prior authorization requests for most pharmacy benefit drugs. In addition, an ePA tool can be integrated into your current electronic health record workflow. Check with your vendor to see if you have software that accommodates an ePA tool.

Providers will be asked for specific information that substantiates the request. Providers are encouraged to have the member's chart readily available when calling. To request prior authorization or an exception request, the provider should contact the Blue Cross Clinical Pharmacy Help Desk at 1-800-437-3803 from 8 a.m. to 9 p.m. Eastern time Monday through Friday.

Fax requests to: 1-866-601-4428

Mail requests to:

Blue Cross Blue Shield of Michigan
Clinical Pharmacy Help Desk
Mail Code 512J
P.O. Box 441877
Detroit, MI 48244

ePA submission: For information on how to submit requests electronically, training resources or additional assistance, please visit the Pharmacy Benefit Drugs page on ereferrals.bcbsm.com.

The provider should alert the Pharmacy Help Desk if the request is urgent. Urgent requests include requests for drugs without which the member's life, health or ability to regain maximum function would be jeopardized or that, in the opinion of the prescriber with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment requested. The provider should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

Approvals

Prior authorization is entered into the system and notification is provided to the prescriber and member in writing.

Denials

Written notification will be provided to the prescriber and member including the reason for denial and suggested alternatives as well as a

copy of the appeal process.

If you have any questions about this process, or need to make an urgent request, please call the Pharmacy Clinical Help Desk at **1-800-437-3803**.

Starting August 1, 2025, NovoLogix® will no longer manage prior authorization requirements for medical benefit drugs. Blue Cross will manage PA requirements for these drugs.

Prior authorization of prescription drugs covered under the medical benefit – Medicare Part B

The Medicare Advantage PPO Prior Authorization and Step Therapy Program helps ensure that all members receive high-quality, cost-effective pharmaceutical care. To meet this objective, Medicare Advantage PPO requires prior authorization for certain medications, and clinical criteria must be met before coverage is approved. Clinical criteria are based on current medical information and the recommendations of the Blue Cross and BCN Pharmacy and Therapeutics Committee. Drugs that are subject to step therapy may require previous treatment with one or more preferred drugs prior to coverage.

Note: See the "Oncology Value Management program" below for information about oncology medical benefit drugs.

Select Part B medications require prior authorization and/or step therapy when administered in all settings except for inpatient hospital (site of care 21). Prior authorization is required for these professional claims when submitted on a CMS-1500 claim form or electronically via an 837P transaction. Authorization is also required when submitting a claim using a facility claim form such as a UB-04 or electronically via an 837I transaction. We want providers to use the most effective procedures with an understanding of CMS coverage guidelines for medical necessity, safety and efficacy. A list of medications requiring prior authorization is updated periodically.

How to request a prior authorization (organization determination):

Please submit prior authorization requests through the NovoLogix® online tool through our provider portal through July 31, 2025. Beginning Aug. 1, 2025, submit prior authorization requests through the Medical and Pharmacy Drug PA Portal, also accessed through our provider portal.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and choose the BCBSM/BCN logo.
3	Click the *NovoLogix Medicare Plus Blue* tile on the Applications tab for requests through July 31. Beginning Aug. 1, click the *Medical and Pharmacy Drug PA Portal* tile.

If you experience technical difficulties with Availity Essentials, please contact **1-800-282-4548** from 8 a.m. to 8 p.m. Eastern time Monday through Friday.

If you are unable to access Availity Essentials to submit your prior authorization request, you may call the Pharmacy Clinical Help Desk at **1-800-437-3803**, Monday through Friday, 9 a.m. to 4 p.m., Eastern time.

Determinations

The provider will receive written notification via fax of the prior authorization organization determination.

Approvals

Prior authorization is entered into the system and notification is provided to the prescriber and member in writing.

Denials

Written notification will be provided to the prescriber and member including the reason for denial and suggested alternatives as well as a copy of the appeal process.

Retroactive review

Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless (providers may not bill members for these services). If the request is within 90 days from the date of service, providers should submit the request through the NovoLogix online tool.

RC Claim Assist

RC Claim Assist is a web-based resource that provides an overview of medical drug products and a calculation tool to identify the correct National Drug Code and CPT codes to bill, along with the correct NDC quantity, unit of measure and HCPCS billable units, according to the package information. It is available at no cost to all Blue Cross Blue Shield of Michigan and Blue Care Network contracted providers who bill for drugs covered under the medical benefit.

How to access RC Claim Assist

Providers can access RC Claim Assist on our provider portal.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and then choose the BCBSM/BCN logo.
3	Click the *RC Claim Assist medical drug coding tool* on the Applications tab.

For more information or questions about using RC Claim Assist tool, refer to our FAQ document on Blue Cross' ereferrals.bcbsm.com website.

Beginning April 1, OncoHealth® will manage prior authorization requests for pharmacy benefit oncology drugs

Oncology Value Management program

Through the Oncology Value Management program, OncoHealth manages prior authorizations for medical oncology drugs. For dates of service on or after April 1, 2025, OncoHealth also manages pharmacy benefit oncology drugs. For more information on the Oncology Value Management program through OncoHealth, review the FAQ for providers document.

Medical benefit oncology drugs

OncoHealth manages prior authorization requests for medical benefit oncology drugs for dates of service on or after Jan. 1, 2025. Carelon Medical Benefits Management managed these drugs for dates of service before Jan. 1, 2025.

Important: Blue Cross Blue Shield of Michigan and Blue Care Network will continue to manage prior authorization requests for cellular and gene therapies, such as CAR-T.

Oncology and supportive care medications that require prior authorization can be found on the Medical Drug and Step Therapy Prior Authorization List.

Pharmacy benefit oncology drugs

For dates of service on or after April 1, 2025, OncoHealth manages prior authorization requests for pharmacy benefit oncology drugs. The Blue Cross pharmacy department managed these drugs for dates of service before April 1, 2025.

To determine which oncology pharmacy benefit oncology drugs require prior authorization, see the 2025 Drug Lists for Medicare Members on **bcbsm.com**.

Retroactive review

The retroactive period is 365 days from the date of service. Providers should submit retroactive requests through OncoHealth OneUM™ online tool or call OncoHealth Client Support Team at 1-888-916-2616. Because the Oncology Value Management program transitioned from Carelon to OncoHealth, providers should submit retroactive authorization requests with dates of service on or before Dec. 31, 2024, to OncoHealth.

Medicare Plus Blue appeals information

Standard appeal

Blue Cross Blue Shield of Michigan
Medicare Advantage
Grievances and Appeals Department

P.O. Box 2627
Detroit, MI 48231-2627

Fax: 1-877-348-2251

Fast appeal

Fax: 1-877-348-2251

Specialized medications administered in a facility

CAR-T therapies such as Abecma®, Breyanzi®, Yescarta®, Kymriah®, Tecartus™ and Carvykti™ are covered under the medical benefit and require prior authorization. Providers should submit a prior authorization request for CAR-T therapy before rendering the service for all sites of care. OncoHealth does not administer the CAR-T prior authorization program.

Providers must submit the prior authorization request through the NovoLogix online tool or fax it to the Pharmacy Part B help desk at 1-866-392-6465. Be sure to submit all relevant clinical documentation along with the CAR-T request. Send any questions or inquiries to MASRX@bcbsm.com.

Pre-service appeals (appeal of a denied prior authorization)

If a service is denied, an appeal may be filed to have the request reviewed again. Refer to your denial letter for the appeal process.

How to request an appeal (reconsideration)

Standard appeal

Blue Cross Blue Shield of Michigan
Medicare Advantage
Grievances and Appeals Department
P.O. Box 2627
Detroit, MI 48231-2627

Fax: 1-877-348-2251

Fast appeal

Fax: 1-877-348-2251

Post-service appeals (appeal of a denied claim)

Once a claim has been denied, a first-level appeal must be filed to have the request re-reviewed. Please reference the *Provider dispute resolution process* section for your appeal rights.

Note: Original Medicare benefit coverage rules and benefit exclusions / limitations on the member's plan will apply. Providers must obtain prior authorization approval and also verify the member's benefits to be eligible for claim payment on the date of service. Providers may be held financially liable if services are rendered without a prior authorization approval. Providers may not bill members for services that required but did not receive prior authorization.

Resources

You can find a current drug list and our medical policies and prior authorization request forms here:

- For Providers: Help Center – Scroll down to Medicare Advantage and click on the link "How Do I Submit a Drug Prior Authorization Request for Medicare Plus Blue PPO and BCN Advantage?"

You can access more information on Medicare Plus Blue Medical Benefit Drugs here:

- ereferrals.bcbsm.com/bcbsm/bcbsm-drugs-medical- benefit.shtml

Prior authorization of advanced imaging and cardiology services — Carelon Medical Benefits Management

All contracted Medicare Plus Blue PPO physicians are required to contact Carelon Medical Benefits Management before ordering the following services for Medicare Plus Blue members, including UAW Retiree Medical Benefits Trust members with Medicare Plus Blue coverage:

- Select advanced imaging
- Outpatient cardiology
    - Cardiac resynchronization therapy
    - Implantable cardioverter defibrillator
    - Arterial ultrasound services

The exception is Percutaneous Coronary Intervention CPT codes, which require post-service review to validate the clinical appropriateness of the service, because prior authorization is not required in the hospital inpatient, emergency room or urgent care setting.

The program is designed to help ensure the most appropriate test is utilized for the diagnosis in question. This comprehensive approach to managing outpatient diagnostic utilization provides an interface for new technology procedures.

An authorization must be obtained for these services to receive reimbursement. Without an authorization, claims will be denied with no member liability. If necessary, providers can request retroactive authorizations up to 90 days after the date of service.

Either the ordering or rendering physician may obtain prior authorization. However, the rendering physician should verify that the prior authorization has been obtained prior to performing the service.

Members will receive prior authorization approval letters. Providers and members will also receive written notification of prior authorization denials with all applicable appeal rights.

See the Procedure codes for which providers must request prior authorization document to determine the outpatient advanced imaging

and cardiology services that require prior authorization. Providers can request prior authorization from Carelon through our provider portal:

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and choose the BCBSM/BCN logo.
3	Click on the *Carelon ProviderPortal* tile on the Applications tab.

Providers can also obtain prior authorization by logging in to the Carelon provider portal directly. For more information on Carelon's program and clinical review process, view their FAQ for providers page on their website.

Prior authorization of outpatient radiation oncology services — EviCore by Evernorth®

Blue Cross Blue Shield of Michigan's prior authorization program requires all providers to obtain prior authorization for medical necessity for outpatient radiation oncology for Medicare Plus Blue PPO members who reside in Michigan and use Michigan providers. More information on Blue Cross Oncology Services is available here.

EviCore by Evernorth®, formerly eviCore healthcare®, administers the prior authorization program for these services.

EviCore is a national specialty benefit management company that focuses on managing quality and use for individual patients. The prior authorization program is intended to eliminate the unnecessary use of certain procedures, which improves patient care and manages health care costs. Services performed without prior authorization may be denied for payment, and you may not seek reimbursement from members.

You may initiate a prior authorization request through our provider portal.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* on the menu bar and choose the BCBSM/BCN logo.
3	Click the *EviCore Provider Portal* tile on the Applications tab.

The EviCore provider portal is available 24/7, 365 days per year. The Provider's Hub page has training resources, clinical guidelines and worksheets, along with other helpful information. The clinical worksheets will help guide you with the necessary information to request a prior authorization.

To ensure the prior authorization process is as quick and efficient as possible, include the following required information when submitting a prior authorization request:

- Member name, date of birth, plan name and plan ID number
- Ordering physician's name, National Provider Identifier (NPI), Tax Identification Number (TIN) and fax number
- Place of service
- Rendering facility's name, NPI, TIN, street address and fax number
- Service being requested (CPT codes and diagnosis codes)
- All relevant clinical notes; imaging/X-ray reports, patient history and physical findings

Prior authorization requests must be submitted to EviCore before any outpatient radiation oncology services are rendered. Additional instructions follow.

Outpatient radiation oncology requests may be made only by telephone or web portal.

If an authorization is going to be denied, the provider may request a peer-to-peer conversation. If the service isn't performed within the valid date span of the issued prior authorization, a new prior authorization must be requested.

The recommended and quickest way to obtain prior authorization is online. If a prior authorization isn't obtained for the outpatient radiation oncology services, claims will be denied, and providers will be responsible for the costs and the member must be held harmless.

We recommend that the ordering physicians secure the required prior authorizations and provide the prior authorization numbers to the rendering facilities or providers at the time of scheduling. Authorization records will contain prior authorization numbers and one or more CPT/HCPCS codes specific to the services authorized. Services performed in conjunction with 23-hour observation or emergency room visits are not subject to prior authorization requirements. Inpatient hospital admissions require separate prior authorization via the e-referral system.

Prior authorizations will be excluded for:

- Facility claims for emergency/trauma, observation, urgent care, treatment room, other labor room and VA hospitals
- Professional claims for emergency/trauma and inpatient
- Radiation oncology patients under 18 years of age

When a service requiring prior authorization is medically urgent, the provider must call EviCore at 1-877-917-2583 (BLUE) for prior

authorization. Expedited or urgent requests must contain a doctor's attestation that the services are necessary for a condition that is jeopardizing the member's life or health and is deemed life threatening. Expedited or urgent requests will be processed within four hours and will be processed by the end of the business day.

For all services, if there is not enough information to grant a medical necessity approval, EviCore will reach out to providers prior to denying a request to allow them to provide pertinent information. Providers must call 1-877-917-2583 (BLUE) to schedule a peer-to-peer review. Providers have one business day to schedule a peer-to-peer review. If there is no response within one business day, the request will result in a formal denial. After a peer-to-peer review, the request will be formally approved or denied. Written denial notices will be sent to the member as well as the requesting provider(s). Once a service has been denied, an appeal must be filed to have the request re-reviewed.

Pre-service appeals (appeal of a denied prior authorization): If a service is denied, you may file an appeal to have the request reviewed again. Refer to your denial letter for the appeal process.

Post-service appeals (appeal of a denied claim): Once a claim has been denied, you must file a first-level appeal to have the request re-reviewed. Please refer to the *Provider dispute resolution process* section for your appeal rights.

EviCore will conduct a retroactive review if requested within 365 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless.

Prior authorization of musculoskeletal surgical procedures, including orthopedic, pain management and spinal procedures – TurningPoint

TurningPoint Healthcare Solutions LLC manages inpatient and outpatient authorizations for musculoskeletal surgical and related procedures for Medicare Plus Blue members. This includes orthopedic, pain management and spinal procedures.

REMINDER: For dates of service on or after May 1, 2025, pain management services for Medicare Plus Blue members no longer require prior authorization requests. Refer to musculoskeletal procedure authorizations for information about how to submit retroactive authorization requests for pain management services on or after May 1, 2025, for dates of service before May 1, 2025.

TurningPoint provides an aligned and comprehensive musculoskeletal utilization program for our Medicare Plus Blue members. They have specialty board certified surgeons, past presidents and current board members of the North American Spine Society that ensure there is adherence to CMS guidelines including applicable NCDs and LCDs, evidence-based guidelines, and clinically appropriate care for musculoskeletal services.

For more information regarding TurningPoint, see the Musculoskeletal Services page and the Pain Management Services page on Blue Cross' ereferrals.bcbsm.com website. On this page, you'll find links to the provider FAQ document and additional resources. The FAQ document includes hours and days of operation, contact information, methods for submitting prior authorization requests, how to submit a claim for an emergent procedure and more. If a provider needs to request a prior authorization after hours or on weekends or holidays, TurningPoint medical professionals are on-call 24 hours a day, 7 days a week.

Providers can submit retroactive requests for up to 90 days after performing a procedure.

Musculoskeletal surgical and related procedures that originate in the emergency department

Reminder: You don't need to request prior authorization for musculoskeletal procedures that are performed urgently or emergently during an inpatient admission or because of a direct admission.

Submit claims for medical emergencies with an emergency indicator of Y on the CMS-1500 claim form or in Loop 2400 Segment SV109 of the 837P claim transaction.

Pre-service appeals (appeal of a denied prior authorization)

If a service is denied, you may file an appeal to have the request reviewed again. Refer to your denial letter for the appeal process.

Portal registration and access
Provider offices can access the TurningPoint Provider Portal through our provider portal.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and choose the BCBSM/BCN logo.
3	Click the *TurningPoint Provider Portal* tile in the Applications tab.
4	Choose a provider and provider type, and then click *Submit*.

If you're having trouble accessing the TurningPoint provider portal using this process, contact Availity at 1-800-AVAILITY (282-4548).

If you have any questions or need assistance regarding requesting a prior authorization, email TurningPoint at portalregistration@turningpoint-healthcare.com.

Out-of-state providers: To request prior authorizations from TurningPoint, refer to our provider FAQ document on musculoskeletal

procedure authorizations, and review the section titled "How do I submit prior authorization requests to TurningPoint?"

Providers who want to submit requests through the TurningPoint website: Refer to our provider FAQ document on musculoskeletal procedure authorizations, and review the section titled "How do I register for direct access to the TurningPoint Provider Portal?"

Prior authorization of behavioral health services

As of Jan. 1, 2024, Blue Cross Behavioral Health℠ manages behavioral health prior authorization services for Medicare Plus Blue members. All autism services, as well as mental health and substance use disorder inpatient, partial hospital and intensive outpatient treatment admissions or concurrent reviews require prior authorization, which should be submitted through our provider portal.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and choose the BCBSM/BCN logo.
3	Click the *Blue Cross Behavioral Health* tile in the Applications tab.

For additional information, refer to the document *Blue Cross Behavioral Health: Frequently asked questions for providers*.

Note: This process excludes acute detoxification admissions. Acute detoxification admissions should be processed as a medical service and should follow the prior authorization requirements for medical inpatient admission.

Services that require prior authorization include:

- Initial admissions for inpatient, partial hospitalization and intensive outpatient treatment for members who have been admitted to inpatient care or to a treatment program
- Extensions of inpatient, partial hospitalization and intensive outpatient treatment

Outpatient behavioral health services for Medicare Plus Blue members do not require prior authorization.

Blue Cross Behavioral Health can be reached at **1-888-803-4960** for general assistance with behavioral health services including:

- Arranging services or requesting authorization for services.
- Obtaining criteria used to make an authorization decision (LOCUS/CALOCUS or ECSII).

Note: The Behavioral Health page on ereferrals.bcbsm.com also contains resource materials, such as clinical program requirements, that can assist providers in managing behavioral health services.

Our Behavioral Health Services clinicians are available 24 hours per day, seven days a week for urgent provider issues or member emergencies.

Note: If you fail to submit your authorization request, submit an untimely request, or your request is denied and you still execute the service, the member must be held harmless.

Providers who fail to obtain authorization for these services may receive denials for all claims that do not have an associated authorization, and may incur complete financial responsibility for all services rendered without authorization.

Providers may obtain a copy of the criteria used to render all decisions and request a peer-to-peer conversation with the behavioral health medical director regarding medical necessity decisions by calling Medicare Plus Blue PPO Behavioral Health Services at 1-877-293-2788 between 8 a.m. and 8 p.m. Eastern time Monday through Friday. Blue Cross will contact you by the next business day. We schedule peer-to-peer reviews between 9 a.m. and 4 p.m. Eastern time Monday through Friday (except holidays).

Prior authorization of acute care admissions to hospitals

Emergency and post-stabilization care services

Blue Cross does not require notification or authorization of emergent or post-stabilization care services.

Blue Cross' financial responsibility for post-stabilization care services ends when the below conditions occur (CFR: 42 CFR § 422.113(c)(3)(i-iv):

- Physician with privileges at the treating hospital assumes responsibility for member's care.
- Physician assumes responsibility for the member's care through transfer.
- Blue Cross and the treating physician reach an agreement concerning the member's care.
- The member is discharged.

Note: Blue Cross does not require an observation order when reimbursing an observation claim.

CMS two-midnight rule

The 2024 CMS Medicare Advantage Final Rule clarified and codified guidance to Medicare Advantage plans requiring plans to follow and apply the two midnight rule. "An MA plan must provide coverage, by furnishing, arranging for, or paying for an inpatient admission when, based on a consideration of complex medical factors documented in the medical

record, the admitting physician expects that either of (d)(1) – (d)(3) are satisfied," per *Code of Federal Regulations "Admissions" 42 CFR 412.3(d)(1)-(3)*.

According to Medicare coverage guidelines, there are three conditions that require reimbursement for hospital-based services:

1. (d)(1) Two-midnight benchmark: a patient is generally appropriate for hospital level of care if the patient meets two qualifications:
    a. The admitting physician expects the patient to require a medically necessary hospital care spanning two or more midnights.
    b. The expectation is supported by the medical record clinical documentation of the members severity of illness and intensity of services required.
2. (d)(2) Hospital admission is for a surgical procedure specified by Medicare as inpatient only (CMS IPO List). MA plans cannot apply additional coverage criteria.
3. (d)(3) Case-by-case exception – the admitting physician expects the patient to require hospital care only for a limited time and it does not cross two midnights. In these cases, the factors that lead to the decision to admit to inpatient status MUST be documented in the medical record to grant consideration and the documentation must support the member's severity of illness and intensity of services.

The two-midnight presumption is an instruction given to the Medicare Administrative Contractor which states if the hospital stay spans two or more midnights, the hospital care is reasonable and necessary and thus will not be selected for review unless there is evidence of abuse or delays in the provision of care to qualify for the two-midnight presumption. The provider is given the benefit of the doubt that these admissions meet medical necessity.

CMS states that the two-midnight rule 'presumption' is inapplicable to MA plans. See www.federalregister.gov/d/2023-07115. Refer to CMS Final Rule pdf, p. 22192.

Medicare Plus Blue is not required to follow the two-midnight presumption. Thus, Medicare Plus Blue's utilization management program can choose to review authorization requests at any point in the hospital stay.

Medicare Plus Blue follows the two-midnight benchmark and CMS requirement that only allows coverage and payment for services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member except as specifically allowed by Medicare (US Government Publishing Office. Electronic code of federal regulations: part 412.3 – Prospective payment systems for inpatient hospital services. Admissions. www.ecfr.gov.** Published August 13, 2013. Updated November 16, 2021).

Under the benchmark, surgical procedures, diagnostic tests and other treatments will generally be considered appropriate for inpatient hospital admission and payment when the physician expects the member, based on complex medical factors documented in the medical record to require a hospital stay that crosses at least two midnights and admits the member to the hospital based on that expectation.

According to CMS, complex medical factors include the following (Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered under Part A)**

- Member's medical history and current medical needs
- Types of facilities available to inpatients and outpatients
- The relative appropriateness of treatment in each setting
- The severity of the signs and symptoms exhibited by the member
- The medical predictability of something adverse happening to the member
- The need for diagnostic studies that appropriately are outpatient services to assist in assessing whether the member should be admitted
- The availability of diagnostic procedures at the time when and at the location where the member presents

All hospital services must be reasonable and necessary to be covered. Medicare Part A payment is prohibited for care rendered for social purposes or reasons of convenience that are not medically necessary. Factors that may result in an inconvenience to a member, family, physician or facility do not, by themselves, support Part A payment for an inpatient admission (Medicare Program Integrity Manual, Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services**)

For coverage of an inpatient admission under Medicare the clinical documentation must clearly support the medical necessity of the inpatient admission as evidenced by severity of illness and intensity of services to warrant need for inpatient medical care. If uncertain that an inpatient admission is appropriate, then consider placing member in observation status.

Medical necessity

Medical necessity is defined as services needed to diagnose or treat a physical or mental condition. The fact that a healthcare provider has prescribed, performed, ordered, coordinated a service or course of treatment, recommended or approved items or services does not, in itself, make such items or services medically necessary. Those services provided in a hospital on an inpatient basis are ones that cannot be

effectively furnished more economically on an observation or outpatient basis.

To be medically necessary, the services must:

- Be widely accepted as effective
- Be appropriate for the condition or diagnosis
- Be essential based on nationally accepted evidence-based standards
- Cost no more than a treatment that is likely to result in a comparable health outcome
- Be the most appropriate level of care and site of service which can be safely and reasonably provided
- Medically appropriate based on adequate management of medical comorbidities and risk factors for death or complications
- Be surgically appropriate for the condition or diagnosis based on the CMS Inpatient Only List or nationally accepted evidence-based standards

All requests for inpatient level of care are subject to a medical necessity review. In making a determination to reimburse inpatient level of care based on medical necessity, Blue Cross has the right to determine the medical necessity of the physician attesting to the member requiring at least two midnights of hospital care. Decisions will consider the member's benefit plan, national/local medical coverage guidelines, our internal criteria of InterQual as a source of medical evidence to support medical necessity and level of care, the member's medical history, physician recommendations and clinical documentation.

The hospital will receive payment under Part A as long as the hospital can demonstrate through appropriate documentation that the admitting physician's expectation is consistent with Medicare coverage rules, supplemented by our internal coverage criteria. No service is covered unless it is medically necessary.

Medicare Plus Blue guidelines

Here are some guidelines that clarify how Medicare Plus Blue determines medical necessity:

- Medicare Plus Blue uses CMS coverage guidelines, CMS Inpatient Only List and our internal coverage criteria, InterQual criteria (for all admissions) to make determinations of medical necessity for all Medicare Plus Blue members.
- Medicare Plus Blue requires physician certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. Certification is mandated in the Original Medicare rule

found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B** and 42 CFR 412.3**.

- If an inpatient level of care is denied because it does not meet our internal criteria, InterQual, as the admission was not medically and necessary for inpatient reimbursement, the facility may bill and be reimbursed for Part B inpatient services that would be reasonable and necessary as member was treated as observation/outpatient. No services should be billed as ancillary only (TOB 0121).

Submitting acute inpatient authorization requests

The time frame within which Blue Cross must make a determination on a request to authorize an acute inpatient admission depends on the type of request. Refer to the table below for the details.

Request for…	Time frame for determination	Standard set by…
Preservice expedited organization determination	Within 72 hours of receipt of request	CMS
Preservice standard organization determination	Within 14 calendar days of receipt of request	CMS
Concurrent standard organization determination	Within 14 calendar days of receipt of request	CMS
Post-service standard organization determination	Within 14 calendar days of receipt of request	CMS

E-referral requests are required when a physician assumes responsibility for the member's care, and the member is moved from observation to inpatient status. Providers must notify Blue Cross of acute non-behavioral health inpatient admissions once a member is admitted to inpatient status. Providers must submit supporting clinical documentation that shows the inpatient admission meets applicable Medicare coverage guidelines and Medicare Plus Blue's internal clinical coverage criteria guidelines of InterQual. Most requests for acute inpatient admissions must be submitted to Medicare Plus Blue using the e-referral system. However, there are some exceptions that must be submitted by fax.

For information on how to submit inpatient admission authorization requests, including transfers of acute care inpatients to other acute care facilities, refer to the document *Submitting acute inpatient authorization requests: Frequently asked questions for providers*.

Note: Medicare Plus Blue members admitted to an inpatient acute care medical/surgical (non-behavioral health) facility may request a non-emergency transfer to another facility of their choice at any time.

Failure to obtain a timely authorization may result in the following payment sanctions:

- If an acute care admission notification is received within 60 days from date of admission, Blue Cross will not apply a payment sanction.
- If an acute care admission notification is received after 60 days from the date of admission, Blue Cross will apply a 30% payment sanction.
- If an acute care admission notification is not received or is received and rejected, Blue Cross will apply a 100% payment sanction.

Members must be held harmless and cannot be billed for any amount remaining on the claim due to the application of a payment sanction.

Payment sanctions for failure to comply with notification processes do not impact behavioral health (covered in the previous Utilization Management section) skilled nursing facility, inpatient rehabilitation, or long-term acute care admissions, which are covered in the sections below.

If you're not an e-referral user already, you can find instructions to sign up for or change a user on the Register for web tools page on bcbsm.com. The page contains information providers need to sign up for access to the e-referral system. The e-referral page also contains information on authorization and referral criteria as well as other services that are subject to prior authorization.

The e-referral system requires the provider to submit clinical documentation to support meeting Blue Cross' admission criteria. Required information is outlined below:

- Hospitals are required to apply InterQual criteria (for all admissions), and, as applicable, CMS Inpatient Surgical List for inpatient admissions.
- Clinical information from the medical record must be attached to the authorization submission to validate appropriateness of the inpatient setting.

Guidelines for submitting clinical information

For inpatient acute medical / surgical admissions of Medicare Plus Blue members, we require admitting physicians and facilities to submit only requests that have a complete set of clinical information outlined below and the physician's order to admit to inpatient.

- Submit documentation that supports the medical necessity of a hospital admission crossing two midnights, in line with the member's severity of illness, the intensity of the services required and the admitting physician's order to admit to inpatient level of care.
- Attach all pertinent clinical information from the medical record to the authorization request to validate that an inpatient setting is appropriate.

- Include the following clinical documentation with the request:
  - Emergency room, observation and/or transferring facility clinical documentation as applicable
  - Date and time of inpatient admission and physician's admission order
  - InterQual criteria subset used to support the decision for inpatient admission
  - Pertinent clinical information that validates the InterQual criteria points have been met. Include dates, times and trend documentation. (Note: Many criteria points have findings and interventions that require frequencies, dosages and time-based intervals to demonstrate InterQual indications have been met.)
  - Procedure code from the CMS inpatient surgical list that was used to support the decision for an inpatient admission.

If a request is pended for clinical review, our clinicians will use the clinical information the provider submitted to support a medical necessity determination.

Note: Facility review programs are generally initiated by staff of the relevant facilities; however, physicians are expected to support these programs as needed by providing appropriate clinical information and other needed data. See the *Providing Medicare Outpatient Observation Notice (MOON)* section of this manual for information on prior authorization for members moving from observation to inpatient status.

For issues related to inpatient admissions of Medicare Plus Blue members, please call the appropriate number below:

- Business hours: 1-866-807-4811
- After hours: 1-800-851-3904

Prior authorization of other medical/surgical services

Medical necessity criteria

Select elective medical/surgical procedures require prior authorization for members who reside in Michigan and use contracted Medicare Plus Blue PPO physicians. The prior authorization program is intended to eliminate the unnecessary use of certain procedures, which improves patient care and manages health care costs. Services performed without authorization may be denied for payment, and you may not seek reimbursement from members.

To see a list of elective (non-emergency) procedures or services that require you to answer questions in the e-referral system to obtain prior authorization, see the Preview questionnaires and medical necessity criteria document. Through this document, you can access the following:

- Information about accessing medical policies

- Preview questionnaires to help you prepare answers ahead of time (includes code listings and the information required for each service)
- Criteria sources

When making utilization management determinations on your prior authorization requests we use:

- Medicare national coverage determinations, if available
- Medicare local coverage determinations (in the absence of national coverage determinations)
- InterQual criteria or our Medicare medical policies if no NCDs, LCDs or other Medicare guidance exists

Requests for prior authorization should be submitted via e-referral at least 14 days in advance of the procedure. A questionnaire may display when you submit the request. After completing the questionnaire, you will get an immediate approval if the criteria are met. When the criteria aren't met based on the answers that you provide on the questionnaire, the case will pend for review by our clinical staff.

For expedited or urgent requests, the provider must call Blue Cross at **1-800-392-2512**. Expedited requests will be handled within 72 hours.

Clinical information is required for all requests where the case pends for clinical review. To prevent delays in our ability to make decisions, submit the clinical information when you load the request in the e-referral system in a Case Communication. If clinical information is not received, the provider will be contacted through the Case Communication in e-referral by phone or in writing to request the necessary information. If documentation is not received within the designated timeframe, the service may be denied.

When an organization determination is made, the requesting and treating providers and the member will receive written notification of the decision. If the service is denied, the letter will explain the reason for denial, instructions for filing an appeal and information on how to reach the plan medical director who made the decision. Providers can also view the status of the request on e-referral.

Blue Cross will conduct a retroactive review if requested within 90 days from the date of service. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless (providers may not bill members for these services). These requests may be submitted through the e-referral system.

Questionnaire validation

On occasion, we'll pend some authorization requests that would usually be auto-approved based on your answers to the questionnaires in the

e-referral system. This will allow us to validate the answers you provided on the questionnaire.

When we pend a request, you'll get this message in the e-referral system: "Case requires validation. Medical records required. Please attach clinical information from the patient's medical record applicable to this request in the Case Communication field."

For instructions on how to attach clinical information to the authorization request in the e-referral system, refer to the e-referral User Guide. Look in *Section IV: Referrals and Authorizations* under "Submit a Referral" for the Create New (communication) paragraph.

When we receive the clinical information, we'll review it to confirm that it supports the information you provided in the questionnaire, and then we'll make a determination. If we don't receive the clinical information, or if the clinical information you send doesn't support your answers in the questionnaire, we may not be able to approve the request.

Criteria request form

The criteria used to make a determination on a specific authorization request are available to providers upon request. To request the criteria, complete the Criteria request form and fax it to the number on the form. Access the form on the Blue Cross Authorization Requirements & Criteria page on our ereferrals.bcbsm.com website. Look under the "Forms – Medicare Plus Blue" heading.

Note: Use this form only for criteria related to non-behavioral health authorization determinations and only for determinations made by Blue Cross, not those made by our contracted vendors.

Prior authorization of SNF, LTAC, and inpatient rehabilitation stays

Submit prior authorizations for SNF, LTAC and inpatient rehab to Blue Cross

Blue Cross Blue Shield of Michigan manages prior authorizations and service extension requests for inpatient admissions to skilled nursing facilities, long-term acute care facilities and inpatient rehabilitation facilities for Medicare Plus Blue members living in Michigan and Medicare Plus Blue members with a non-Michigan permanent address who will receive services from Michigan post-acute care facilities.

Blue Cross reviews a patient's current clinical condition and proposed treatment plan. Blue Cross' prior authorization program is designed to determine, in advance of an admission, whether the patient meets nationally recognized clinical screening criteria for SNF, LTAC and IP rehabilitation admission and the level of care planned.

All Michigan contracted Medicare Plus Blue PPO providers are required to submit a prior authorization request before admitting a Medicare Plus Blue PPO member into these facilities. It is our expectation that a clinician will provide the appropriate clinical information and documentation regarding the member's condition. Blue Cross uses

InterQual criteria to screen for appropriate admissions of inpatient rehabilitation and long-term acute care initial prior authorization and extension requests. We use Medicare-appropriate chapter guidance to screen for appropriate stays at skilled nursing facilities. Prior authorization requests that do not meet Medicare guidance or InterQual screening criteria will require a review by a Medical Director.

The prior authorization process works best when hospitals and physicians have a standard procedure for communicating with each other to ensure that prior authorization information is sent timely. The prior authorization program is designed for obtaining certification prior to admission; requests for post-acute care (PAC) facility admissions should be submitted by the hospital case management/discharge planning teams or ordering physician a minimum of 48 hours prior to anticipated discharge. Please be aware that if you fail to submit your prior authorization request, submit a late request, or your request is denied and you still admit the member, all or part of your claim submission may be rejected. The member must be held harmless.

Requesting prior authorization

Please refer to the information in the Post-Acute Care pages on ereferrals.bcbsm.com for additional information to ensure that you submit a timely prior authorization request and execute compliant discharge procedures.

The acute care is responsible for submitting the request to authorize initial admissions.

Note: If the acute care provider is not contracted with the member's health plan, the post-acute care provider will need to submit the authorization request. Post-acute care providers should always confirm that an authorization request has been submitted when accepting a member for care. If an authorization request hasn't been submitted, the post-acute care provider must submit it. In addition, if the member is moving into post-acute care from somewhere other than an acute care setting, the ordering provider must submit the authorization request.

The post-acute care provider must submit requests for continued stays, discharge notifications and retroactive stays.

Submit requests through our provider portal on Availity Essentials.

Requests for prior authorization for skilled nursing facility, long-term acute care or inpatient rehabilitation facility admissions in the state of Michigan may be submitted through Availity Essentials.

For the steps required to access e-referral through Availity Essentials, see the "Submit prior authorization requests" section of the Getting Started page on our **ereferrals.bcbsm.com** website.

For step-by-step directions for working in the e-referral system, see the *e-referral User Guide* and other resources that are available on the Training Tools page of the **ereferrals.bcbsm.com** website.

Step	Action
1	Log in to our provider portal (availity.com**).
2	Click *Payer Spaces* in the menu bar and choose the BCBSM/BCN logo.
3	Click the appropriate tile in the Applications tab.

Required information for all prior authorization and service extension requests

At admission

- History and physical
- Current physician notes and nurses' notes
- Physician orders sheet with medication list
- Physical therapy, occupational therapy and speech therapy evaluations
- Nursing admission assessment
- Prior living situation
- Current cognitive status
- Prior level of function

For continued stays

- Face sheet from skilled nursing facility, inpatient rehabilitation facility or long-term acute care hospital, including name of attending physician
- Complete the LTACH or SNF/acute IPR assessment form
- Hospital discharge summary
- Nursing admission assessment
- Physician order sheet with medication list
- PT, OT and ST evaluations

- Nursing notes
- Therapy notes
- Physician order changes

At discharge

- Discharge date
- Completed NOMNC

Standard recertification requests – Recertification requests should be submitted 72 hours in advance of the current authorization end date. If a request is denied, we will complete the NOMNC form and provide it to the skilled nursing facility to deliver to the member. Failure to follow this process per CMS guidelines may result in an Administrative Denial of Payment. Administrative Denials of Payment may not be billed to the member.

The initial PAC facility admission authorization will allow the member to be admitted to a participating facility any time within 96 hours from the date of approval. If the member is not admitted within 96 hours of the approval, it will expire, and a new authorization request will need to be submitted. When submitting the new authorization request, note why the transfer was delayed and include the original authorization number in the case communication section on the e-referrals website.

Blue Cross will accept a retroactive request for authorization up to one year post-discharge from the PAC facility. The services must meet clinical criteria for appropriateness. Claims submitted for unauthorized procedures are subject to denial, and the member must be held harmless.

Transitional period for members changing coverage

When a member's coverage changes from Original Medicare or another Medicare Advantage plan to Medicare Plus Blue while admitted to a SNF, submit a request to Blue Cross within seven business days of the Medicare Plus Blue coverage effective date to prior authorize any continued stay. If the member does not meet criteria, we will complete the NOMNC form and provide it to the skilled nursing facility to deliver to the member. Failure to follow this process per CMS guidelines may result in an Administrative Denial of Payment. Administrative Denials of Payment may not be billed to the member.

The NOMNC is not to be used when member services end based on the exhaustion of Medicare benefits, such as the 100-day SNF limit (for some benefit plans).

Facilities that fail to authorize all or part of a member's stay prior to discharge will be responsible for any days not previously authorized by the plan. You may not bill the member for days not covered by the plan.

Please reference the *Provider dispute resolution process* section for your appeal rights.

To request a peer-to-peer review the "Inpatient non-behavioral health non-elective admissions" section of the *How to request a peer-to-peer review with a Blue Cross or BCN medical director* document on ereferrals.bcbsm.com.

For information about changes related to post-acute care services for Medicare Advantage members that began Oct. 1, 2024, read our Sept. 18, 2024, provider alert.

For more information about post-acute care services, read our Post-acute care services FAQ document.

Appealing Medicare Plus Blue's Decision

Contracted MI provider acute medical and behavioral health inpatient admission appeals

All Michigan providers have the right to appeal an adverse medical decision made by Medicare Plus Blue Utilization Management. Denials of coverage related to medical necessity or medical appropriateness are made by the plan medical directors and are based on the following:

- Information from the attending physician
- Consideration of the member's benefit coverage
- Review of pertinent medical information
- Clinical judgment of the medical director

At any step in the appeal process, a plan medical director may obtain the opinion of a same specialty, board certified physician or external review board.

Documentation guidelines for submitting an appeal

- Include the following contact information on appeal letter: contact name, phone number, fax and email.
- Appeal letter must contain member name, date of birth, contract number and date of service appealing (date of service should not include observation).
- Identify the reason for denial referenced in the denial letter.
- Include physician's and consult's rationale that supports medical necessity for the admission which is outside of InterQual criteria.
- Include CPT codes for surgical admission.
- Include physician discharge summary if the member has been discharged.

- If a third-party vendor is submitting the appeal on behalf of the facility, ensure the vendor submits the Appointment of Representation (AOR) with the appeal request.

How to request appeals

Non-expedited appeals

Medicare Plus Blue has a **two-level appeal process** for acute inpatient admission denials.

Level one appeal filing time frames

Must be submitted within **45 days of date of denial decision** on denial notification, and requests must include **additional** clarifying clinical information to support the request.

Medicare Plus Blue will notify the provider of the decision within **30 calendar days** of receiving all necessary information.

Level two appeal filing time frames

Must be submitted **within 21 days** from the date of the level one appeal denial decision. Must contain at least one of the following:

- New or clarifying clinical information
- A clear statement of what the provider is requesting

If neither is included, Medicare Plus Blue is not obligated to review the level two appeal request. Medicare Plus Blue **will notify the provider of the decision within 45 calendar days** of receiving all necessary information. The plan's level two appeal decision is final and there are no other appeal options available to the provider.

Submit level one and level two acute inpatient admission appeal requests using e-referral. See the March 2024 article in The Record for information on an interactive e-learning training course for facility providers. This course simulates e-referral so you can quickly learn how to use e-referral's questionnaire and case communication features to submit appeal requests.

For behavioral health admission appeals, submit appeal requests by mail, fax or email:

Mail:

Medicare Plus Blue Behavioral Health Provider Appeal
Blue Cross Blue Shield of Michigan
20500 Civic Center Drive, MC H100
Southfield, MI 48076-4115

Fax: 1-866-315-0442

Email: AABHMAPPO@bcbsm.com

Contracted Michigan provider acute inpatient admission appeals requested outside the filing time frames:

Medicare Plus Blue will deny a level one appeal request submitted outside of the designated time frame with a decision of untimely filing. Medicare Plus Blue will then process it as a level two appeal request, and the decision is final.

Medicare Plus Blue is not obligated to review a level two appeal request submitted outside of the designated time frame.

Note: If Blue Cross receives an appeal request outside the designated time frame, Blue Cross is not obligated to review the case.

Expedited Appeals

Expedited appeals may be requested when circumstances require a decision be made in a short period of time because a delay may seriously jeopardize the life or health of the member. Pre-service expedited appeals can be requested. Concurrent and retroactive requests will not be considered for expedited status. If the decision is to uphold the original denial, then a second-level appeal may be requested. Second-level appeal decisions are final, and no other appeal option is available to the provider.

How to submit expedited appeal requests:

- Submit expedited pre-service acute inpatient hospital admission appeal requests to Grievance and Appeals at 1-877-348-2251.
- For behavioral health admission appeals, call 1-888-803-4960.

Medicare Plus Blue will notify the provider of the decision within 72 hours. The decision of an expedited appeal is final, and there are no other appeal options available to the provider.

Problems with submitting nonbehavioral health inpatient appeals through e-referral?

Email ProviderInptAppealsP2PInquiry@bcbsm.com. Please include screen shots of issue encountered.

When the e-referral system is down, fax or email (do not mail) documents.

Fax: 1-877-495-3755

Email: MedicarePlusBlueInpatientAppeals@bcbsm.com

Providing notices of appeal rights and responding to appeals

Hospitals

Hospitals are required to deliver the Important Message from Medicare (IM), formerly CMS-R-193 and now CMS-10065, to all Medicare Plus Blue PPO enrollees who are hospital inpatients following all CMS guidelines. The IM informs hospitalized inpatient beneficiaries of their

hospital discharge appeal rights. For members with stays of greater than two days, the follow-up copies of the IM must also be delivered.

Members who choose to appeal a discharge decision must also receive the Detailed Notice of Discharge (DND) Form CMS-10066 from the hospital on behalf of the plan in the specified format and within the timeframes specified by law.

The detailed explanation must be issued to the member and a copy returned to the Quality Improvement Organization, along with the requested supporting documentation, within the established timeframe set forth by the QIO in the notification to the provider of the appeal.

When a member files a timely review of the discharge (no later than midnight of the day of discharge) the enrollee is not financially responsible for inpatient services, other than applicable coinsurance and deductibles, furnished before noon of the day after the member receives notice of the QIO determination. Member liability for additional days of service is dependent on the decision of the QIO. For additional information see **CMS 100-04 Chapter 30 §200.4.2** of the Medicare Claims Processing Manual. The facility may not balance bill the member for these services.

The latest versions of the IM Form CMS-10065 and the DND Form CMS-10066 can be obtained at www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html.**

Home health agencies and comprehensive rehabilitation 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 form (NOMNC CMS form 10123-NOMNC), including the time frames for delivery. For copies of the notice and the notice instructions, go to: www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.**

The failure to deliver a valid NOMNC may result in the provider being held financially liable for the continued services until two days after the member receives a valid notice, or until the effective date of the valid notice, whichever is later per **CMS 100-04 Chapter 30 §260.3.6**. Providers may not balance bill the member for these services.

Home health agencies and comprehensive outpatient rehabilitation facilities must provide both members and the Quality Improvement Organization with a detailed explanation on behalf of the plan when contacted by the Quality Improvement Organization about an appeal of a termination of home health agency or comprehensive outpatient rehabilitation facility within the time frames specified by law.

The detailed explanation must be issued to the member and returned to the Quality Improvement Organization, along with the requested supporting documentation, within the established timeframe set forth by the QIO in the notification to the provider of the appeal.

Home health agencies and comprehensive outpatient rehabilitation providers can obtain a copy of the Detailed Explanation of Non-Coverage (DENC, CMS Form 10124-DENC) and instructions at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.**

Post-acute care skilled nursing, inpatient rehabilitation and long-term acute care facilities

Skilled nursing 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 form (NOMNC CMS form 10123-NOMNC), including the time frames for delivery.

For copies of the notice and the notice instructions, go to: www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.**

For decisions to end care driven by Blue Cross, we will complete the NOMNC form and provide it to the skilled nursing facility to deliver to the member. For decisions to end services driven by the provider, the NOMNC should be created and delivered to the member. The failure of the facility to deliver the NOMNC may result in the provider being held financially liable for the continued services until two days after the member receives a valid notice, or until the effective date of the valid notice, whichever is later per CMS 100-04 Chapter 30 §260.3.6. Providers may not balance bill the member for these services.

A valid detailed explanation of non-coverage must be provided to the Quality Improvement Organization when contacted about an appeal of a termination of the skilled nursing facility services within the time frames specified by law.

The detailed explanation must be issued to the member and returned to the Quality Improvement Organization, along with the requested supporting documentation, within the established timeframe set forth by the QIO in the notification to the provider of the appeal.

If Blue Cross makes the decision to end services, Blue Cross will complete and provide the detailed explanation of non-coverage to the skilled nursing facility to deliver to the member. If the provider makes the decision to end services, the NOMNC should be created and delivered to the member. Blue Cross will obtain the medical records and valid signed NOMNC from the skilled nursing facility and send the NOMNC, detailed explanation of non-coverage and medical records to the Quality Improvement Organization.

Detailed Explanation of Non-Coverage form (DENC) CMS Form 10124-DENC and instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.**

Reimbursement

Guidelines

Blue Cross 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 Advantage PPO Provider Agreement.

Blue Cross provides an *Evidence of Coverage* 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 to participating and non-participating providers. Blue Cross 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 plan.

Blue Cross 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.

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 are accessible at FY 2022 April 1 update ICD-10-CM Official Guidelines**
- Medicare Part B supplier number, national provider identifier and federal tax identification number
- The member's Medicare Plus Blue number, including the 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 (02/12) claim form.

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

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

Claim filing

Overview

Medicare Plus Blue billing guidelines and unique billing requirements may be accessed at bcbsm.com/providers/help/medicare-submit-claims. Claims, including revisions or adjustments, that are not filed by a provider prior to the claim filing limit of one calendar year from date of service or discharge will be the provider's liability.

The National Uniform Claim Committee approved a new version of the CMS-1500 Health Insurance Claim Form. Blue Cross Blue Shield of Michigan began accepting the revised CMS-1500 claim form (version 02/12) on Jan. 6, 2014. Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form (02/12).

The 1500 claim form is a paper claim form used by professional health care providers, while the Michigan Status Claim Review Form is used if a claim is rejected or if payment received is different from what was anticipated. This claim form (version 02/12) can be used for both purposes. When submitting a corrected claim, providers are required to complete field 22 of the 1500 claim form. The provider must enter 7 for Replacement of a prior claim or 8 for Void/Cancel of a prior claim in the Resubmission portion of the field (found on the left-hand side of the claim form).

The original claim number must be supplied in the Original Reference Number portion of the field (found on the right-hand side of the claim form).

For more information, contact your provider consultant or visit nucc.org.** The site includes instructions for completing the form.

PCP Select

Blue Cross has added an optional alternative to the retrospective claims-based Medicare Plus Blue attribution model called PCP Select. Medicare Plus Blue members have the option to select a PCP in their member portal. Members who select a PCP will be attributed based on the PCP they selected, rather than via the standard claims model. Members who choose not to select a PCP will continue to be attributed based on the standard claims model.

Selecting a PCP in the member portal won't limit which providers a member can see for care, nor will it affect a member's benefits or claims payments. Instead, it will allow for quicker and more efficient attribution, which will improve data sharing and financial operations

Where to submit a claim

Michigan providers

Type	Medical claims	Dental claims
Electronic	Our EDI services are available on Availity Essentials. Follow the guidelines for electronic billing that are available at bcbsm.com/providers/help/edi. If you have any electronic claims questions, contact Availity Client Services at 1-800-AVAILITY (282-4548) or submit an online support ticket. Log in to availity.com and navigate to Help & Training > Availity Support.	Submit claims on the dental provider portal at provideraccess.dentaquest.com or work with your clearinghouse to submit claims electronically. The DentaQuest Payor ID is BBMDQ.
Paper	Send claims to: Medicare Plus Blue Blue Cross Blue Shield of Michigan P.O. Box 32593 Detroit, MI 48232-0593	Complete the 2012 or newer American Dental Association claim form and mail to: Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231 Fax: 1-262-834-3589

Non-Michigan providers

For electronic medical claim submission, send claims to your local Blue plan. Please see the Ancillary claims section of this manual for more information. Report the prefix to ensure correct routing of the claim.

For dental claim submission, work with your clearinghouse to submit electronic claims. The DentaQuest Payor ID is BBMDQ. Submit paper claims to:

Medicare Advantage
Blue Cross Blue Shield of Michigan
P.O. Box 49
Detroit, MI 48231

Problems submitting claims or billing questions

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

	Electronic claims	Paper claims
Michigan providers	Our EDI services are available on Availity Essentials. Follow the guidelines for electronic billing that are available at bcbsm.com/providers/help/edi. If you have any electronic claims questions, contact Availity Client Services at 1-800-AVAILITY (282-4548) or submit an online support ticket. Log in to availity.com and navigate to Help & Training > Availity Support.	Medical: Call Provider Inquiry: **1-866-309-1719** Dental: Call **1-844-876-7917.**
Non-Michigan providers	Medical: Contact your local Blue plan. Dental: Call **1-844-876-7917**.	Medical: Contact your local Blue plan. Dental: Call **1-844-876-7917**.

Questions about plan payments

Medical Claims

Michigan providers: Call Provider Inquiry at **1-866-309-1719**.

Non-Michigan providers: Contact your local Blue plan.

Dental claims

- Visit the portal at provideraccess.dentaquest.com.**
- Michigan and non-Michigan providers: Call **1-844-876-7917**.

How to perform a status inquiry on claims

Medical claims

You can perform a claims status inquiry by logging in to our provider portal on Availity Essentials. You can also call Provider Inquiry or mail your inquiry.

Step	Action
1	Click on the Claims & Payments down arrow and choose Claim Status
2	Select organization and payer
3	Enter patient information

Call Provider Inquiry at 1-866-309-1719.

Mail your inquiry to:

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

Even though you can check the status of a claim, you cannot adjust or correct any Medicare Plus Blue PPO claim.

Dental claims

- Visit the portal at provideraccess.dentaquest.com.**
- Call **1-844-876-7917**.

Ancillary claims

The Blue Cross and Blue Shield Association has clarified its rules pertaining to how independent laboratories, durable medical equipment suppliers and specialty pharmacies should submit claims in certain circumstances.

These rules also impact referring practitioners. Here are highlights:

- Independent labs should file claims with the plan in whose state the specimen was drawn (determined by where the referring physician is located).
- Durable medical equipment suppliers should file claims with the plan in whose state the equipment or supplies were shipped to (including mail order supplies) or purchased (if it was purchased at a retail store).
- Specialty pharmacies should file claims with the plan in whose state the ordering physician is located.

Keep in mind that Blue Cross doesn't have participation agreements with most providers located outside Michigan. To determine if a lab or DME supplier participates with Blue Cross, health care providers and members can go to bcbsm.com and click on the *Find a Doctor* tab.

We encourage practitioners to refer all Medicare Plus Blue PPO members to network providers whenever possible. Medicare Plus Blue PPO members who receive services from an out-of-network lab, specialty pharmacy or DME supplier cannot be balance-billed. Labs, specialty pharmacies and DME suppliers may collect only applicable cost sharing from these members and may not otherwise charge or bill them.

For more information, contact your provider consultant.

Clinical editing

Medicare Plus Blue PPO uses nationally recognized clinical editing software that automatically compares procedure codes billed on claims against nationally accepted coding and billing standards to check for clinical appropriateness and data accuracy.

The software identifies appropriate relationships between CPT-4 and HCPCS codes for medical, surgical, radiology, laboratory, pathology and anesthesiology procedures based on the following:

- CPT-4, HCPCS and ICD (diagnosis) coding requirements
- AMA and CMS (formerly HCFA) guidelines
- Industry standards
- Current medical policy and literature
- Inappropriate relationships include:
    - Unbundled procedures
    - Incidental procedures
    - Pre- and postoperative care included in a surgical fee
    - Mutually exclusive procedures
    - Upcoding services (billing for a higher level service when a lower level service is warranted or performed)

The system flags inappropriate relationships such as procedures that are potentially cosmetic, experimental, obsolete or dependent on age. The Remittance Advice shows how each service was paid in full, paid in part or denied.

Medicare Plus Blue PPO clinical editing software is reviewed and updated regularly for consistency with nationally accepted coding and billing standards.

Modifier usage guidelines:

Medicare Plus Blue PPO follows CMS and industry-standard billing and reimbursement practices related to the use of procedure code modifiers.

Modifier 59

Blue Cross began editing claim lines when modifier 59 is appended on Medicare Plus Blue claims in November 2022. Modifier 59 indicates that a procedure or service was distinct or independent from other services performed on the same day that are not normally reported together.

Blue Cross follows the National Correct Coding Initiative, or NCCI, program developed by CMS, which helps prevent improper coding by identifying procedure codes that are either mutually exclusive or incidental to one another, or that shouldn’t be reported together due to an overlap in services.

We updated the claims editing process so only select codes appended with modifier 59 will automatically bypass the NCCI code pair edits so two codes can be billed together that would otherwise be denied.

For background information and examples of billing scenarios, review the September 2021 article published in *The Record* or CMS' Medical Learning Network fact sheet** on the proper use of modifier 59.

Some of the most common reasons for clinical editing denials or payment reductions

Procedure unbundling/re-bundling

All procedures must be grouped, or bundled, under the most comprehensive procedure code. There are two types of unbundling and rebundling edits:

- Two or more procedure codes are used to indicate parts of a service for which there is a single, more comprehensive code that accurately describes the entire service but was not included in the claim(s). (Codes A + B should be billed as Code C.)
- Two or more procedure codes are submitted for the same date of service, but one of the codes is a comprehensive code that more accurately represents the services performed and billed. (Codes A + B are billed, but Code A is included in Code B.)

Incidental procedures

A procedure is determined to be incidental when it is performed at the same time as a more complex procedure and is an integral component of the primary procedure. (Codes A and B are billed but Code A is considered a component of the primary procedure, Code B.)

Mutually exclusive

These edits consist of procedure codes for which the technique varies but the outcome is the same, such as a total abdominal hysterectomy or a vaginal hysterectomy. Additionally, procedures that represent overlapping services or report an initial and subsequent service are considered mutually exclusive. (Codes A and B are reported but the relationship is improper. Clinically, B opposes A.)

Duplicate procedures

Procedures or services that are billed more than once on the same date of service may be considered duplicates. If clinical editing detects a duplicate service or procedure, the claim is denied. Examples include:

- Certain procedures can only be performed once in a person's life. The second billed procedure will be denied.
- Certain procedures should only be done a maximum number of times on a single date of service. When a procedure is performed more times than is clinically indicated on a single date of service and the need is not supported by a modifier (such as site modifiers), the duplicate procedure(s) will be denied.

Unlisted codes

A generic code is used when there is not a specific CPT or HCPCS code for the service provided. Unlisted procedure codes require authorization and the submission of clinical documentation.

Invalid modifier or inappropriate procedure code modifier relationship

Not all modifiers or procedure code and modifier combinations are valid. An incorrect combination will result in a denial.

Limit rules

Limit rules determine the appropriateness of units billed.

Cosmetic procedures

The billing of a potentially cosmetic procedure triggers an evaluation of services to determine medical necessity. Medicare Plus Blue PPO handles this through the authorization process.

Age conflicts

The clinical appropriateness of the procedure code reported is inconsistent with the member's age.

Obsolete procedures

Edits identify services that are no longer viewed as clinically appropriate to perform; authorization does not override these rejections.

Investigational

Claims for procedures classified as experimental will be subject to medical review during the Medicare Plus Blue PPO claim's process.

Evaluation and management codes inconsistent with the service rendered

E&M services must be medically reasonable and necessary and must meet the requirements of the CPT code used on the claim. Documentation must support the medical necessity, appropriateness and level of the E&M service billed. E&M codes are subject to E&M coding edits.

Laboratory claims editing

In June 2022, Blue Cross began implemented a laboratory benefits management program on Medicare Plus Blue℠ claims.

Automated policy enforcement (post-service) edits are applied to claims reporting laboratory services performed in office, hospital outpatient and independent laboratory locations in alignment with Blue Cross' laboratory policies. Laboratory services, tests and procedures provided in emergency department, hospital observation and hospital inpatient settings are excluded from this program.

New and revised laboratory medical policies and guidelines are in effect, which will affect certain laboratory, services, tests and procedures. To review medical policies, visit avalonhcs.com/policies-bcbsm.**

Trial Claim Advice Tool

Health care providers can use the Trial Claim Advice Tool to simulate a trial claim by inputting codes for services, along with patients' diagnoses, to determine possible edits in advance of submitting claims. Keep in mind that this is a simulation tool and doesn't guarantee approval or reimbursement of a claim. **Note:** Medicare NCDs and LCDs will supersede Blue Cross' policies when applicable.

To access the tool, follow these steps:

Step	Action
1	Choose BCBSM/BCN under Payer Spaces
2	Click on the Applications tab
3	Click the Avalon Lab Claim Editing square

For more information on laboratory claims editing and laboratory polices, read the article in the May 2022 issue of *The Record*.

How to appeal a clinical editing denial

Clinical editing reconsideration requests can be submitted electronically in Availity Essentials. No separate form is required. For instructions on how to initiate a clinical editing reconsideration request, refer to the document titled Submitting a clinical editing reconsideration request: Instructions.

The appeals process in Availity Essentials allows you to attach documentation while you're in the system. Make sure you submit the accepted file types outlined on the form. It's also helpful to include the service you want us to review in the free-text field with a contact number so we can call if we have questions.

The only appeals accepted through this process at this time are those for claim denials due to clinical editing.

Providers should first review the denial code. In some cases, the use of the Medicare Plus Blue PPO Clinical Editing Reconsideration Request Form is necessary for an appeal. In other cases, the claim should be resubmitted.

The required fields on the Clinical Editing Reconsideration Request Form are marked with a red asterisk. When a form is submitted with required information missing, the appeal will be returned as incomplete.

For an appeal, the date the Clinical Editing Reconsideration Request Form is postmarked or faxed must be within 180 days from the date of the first

Remittance Advice on which the clinical editing denial appears. Providers should include the supporting documentation listed on the form and send the request by mail or fax to:

	Participating providers	Non-contracted providers
Mail	Clinical Editing Appeals Mail Code G820 Medicare Plus Blue PPO 611 Cascade West Parkway, S.E. Grand Rapids, MI 49546-2143	Blue Cross Blue Shield of Michigan Clinical Editing P.O. Box 32391 Detroit, MI 48232
Fax	1-866-526-7179	1-877-348-2251

Clinical editing appeals are typically reviewed within 30 days of receipt and a determination made. If the decision is upheld, the provider is sent a letter to that effect; if the decision is overturned, the appealed claim is processed for payment.

Medicare Plus Blue PPO has only one level of appeal for clinical editing denials. Providers should make sure they submit all pertinent information on the initial request and that the appeal form is complete and accurate. If the appeal is submitted with incomplete or inaccurate information, no additional opportunity for appeal is available.

Some key items to remember with submitting a clinical editing appeal include:

- Fill out the clinical editing form completely and accurately.
- Submit the appeal within 180 days of the original clinical editing denial.

  Note: Appeals submitted after the 180-day time limit will be denied as the filing limit for submitting appeals has been exceeded.
- Include all pertinent clinical information relevant to the appeal. These may include office notes, surgical reports, radiology reports or duplicate reports. The information that should be included depends on the denial received. If in doubt, include it.
- Include a contact person and phone number so Medicare Plus Blue PPO can call you if there are any questions.

For questions about the clinical editing appeal process, visit bcbsm.com/providers/help. Scroll down to Medicare Advantage and click "How do I appeal a Medicare payment or claim?" or call Provider Inquiry at **1-866-309-1719**.

Click here for the **Clinical Editing Appeal Form**.

Note: Providers should always use the most current form, which is available as described here. The online form displays the most updated list of codes that can be appealed.

Provider dispute resolution process

Appeals of claim denials and/or medical necessity claim denials

Note: This is not related to retroactive audits or inpatient medical/surgical admissions.

Contracted providers with Blue Cross' Medicare Advantage PPO have their own appeals rights. Providers may appeal decisions on denied claims, such as denial of a service related to medical necessity and appropriateness. Instead of following the member appeals process, Blue Cross' Medicare Advantage PPO providers should follow these guidelines when submitting an appeal.

Initial appeal requests must be submitted within 60 days of the denial from the date the provider receives the initial denial notice. We will review your appeal and respond to you in writing within 60 days.

Be sure to include the following information with your written request for a **first-level claim denial appeal**:

- Provider or supplier contact information including name and address
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original claim determination
- Documentation and any correspondence that supports your position that the plan's original claim determination was incorrect, including any applicable medical notes and/or medical records (history, physical and operative notes, etc.), Medicare guidance, NCD or LCD when appropriate
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Note: Non-Michigan providers should submit appeals to their local Blue Cross Blue Shield plan.

	Write	Call
Michigan providers	Medicare Plus Blue - Appeals ATTN: First-level appeals Blue Cross Blue Shield of Michigan P.O. Box 33842 Detroit, MI 48232-5842	1-866-309-1719

	Write	Call
Non-Michigan providers	Your local Blue plan	

If you believe that we have reached an incorrect decision regarding your first-level appeal, you may file a **request for a secondary review** of this determination by mailing it to:

Blue Cross Blue Shield of Michigan
Attn: Medicare Plus Blue Second-Level Appeal
P.O. Box 441160
Detroit, MI 48244-1160

A request for secondary review must be submitted in writing within 60 days of written notice of the first-level decision from Medicare Plus Blue PPO. We will review your appeal and respond to you within 60 days. Please provide appropriate documentation to support your appeal, including clinical rationale. **Decisions from this secondary review will be final and binding.**

Be sure to include the following information with your written request for a second-level claim denial appeal:

- Provider or supplier contact information including name and address
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original claim determination
- Copy of the first-level appeal response letter
- Documentation and any correspondence that supports your position that the plan's **first-level appeal review** claim determination was incorrect, including any applicable medical notes and/or medical records (history, physical and operative notes, etc.), Medicare guidance, NCD or LCD when appropriate
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Payment disputes

First-level appeals (medical)

Provider payment disputes include any decisions where there is a dispute that the payment amount made by the Medicare Advantage PPO plan to contracted providers is less than the payment amount that would have been paid under the Medicare fee schedule. 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.

Claims must be disputed within **120 days** from the date payment is initially received. Be sure to include the following information with your written request for a **first-level** payment dispute:

- Provider or supplier contact information including name and address
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original pricing determination
- Documentation and any correspondence that supports your position that the plan's **original reimbursement** was incorrect (including interim rate letters when appropriate, pricer screen prints, etc.)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

We will review your dispute and respond to you within **60 days** from the time we receive notice of your dispute. If we agree with your position, then we will pay you the correct amount. We will inform you in writing if your payment dispute is denied.

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

	Write	Call
Michigan providers	Medicare Plus Blue Provider Inquiry P.O. Box 33842 Detroit, MI 48232-5842	1-866-309-1719
Non-Michigan providers	Your local Blue plan	

Second-level appeals (medical)

If you still believe that we have reached an incorrect decision regarding your payment dispute, you may file a request in writing for a secondary review of this determination within **60 days** of receiving written notice of our first-level decision. To request a secondary review of this determination, write to:

Blue Cross Blue Shield of Michigan
Attn: Medicare Plus Blue Second-Level Payment Dispute
P.O. Box 441160
Detroit, MI 48244-1160

We will review your dispute and respond within 60 days of the date on which we received your request for a secondary review. **Decisions from this secondary review will be final and binding.** Be sure to include the following information with your written request for a **second-level** claim denial appeal:

- Provider or supplier contact information including name and address
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original pricing determination
- Copy of the plan's **first-level** dispute pricing decision letter
- Documentation and any correspondence that supports your position that the plan's **first-level reimbursement review** was incorrect (including interim rate letters when appropriate, pricer screen prints, etc.)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

First-level appeals (dental)

Dental Services	Write
Michigan Dental Providers	Medicare Advantage Blue Cross Blue Shield of Michigan P.O. Box 49 Detroit, MI 48231

Second-level appeals (dental)

If you disagree with the decision made on your first appeal, you may request a managerial level review conference within 60 days of receiving the original decision. The address to request your managerial level review conference is:

Medicare Advantage Dental Provider Grievances & Appeals (second level)
600 E. Lafayette – Mail Code 517K
Detroit, MI 48226

Be sure to include the following information with your request for a secondary review:

- Provider or supplier contact information including name and address
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and physician specialty
- Reason for dispute; a description of the specific issue
- Copy of the provider's submitted claim with disputed portion identified
- Copy of the plan's original pricing determination
- Copy of the plan's first-level dispute pricing decision letter
- Documentation and any correspondence that supports your position that the plan's reimbursement was incorrect (including interim rate letters when appropriate)
- Appointment of provider or supplier representative authorization statement, if applicable
- Name and signature of the provider or provider's representative

Appeal of retroactive audit findings

For retroactive audit disputes, the appeals process contains the following steps:

1. Internal Review
2. External Peer Review

Internal review

You may submit a written request that documents the cases being appealed for an internal review **within 50 calendar days** of receiving our audit determination. You may also submit additional information to support your position.

Within 50 calendar days of receiving your request, we will send you our determination. You may further appeal this determination by requesting an external appeal.

External Peer Review

You may submit a written request that documents the cases being appealed for an external peer review **within 20 calendar days** of receipt of our internal review determination. An independent organization will

perform the second-level review. No additional information can be submitted for a second-level review.

Within 50 calendar days after your submission of medical records, you'll receive a second-level determination letter, which is binding for both of us.

If the outcome is not overturned, you will be responsible for the payment of the external review as well as the initial claim overpayment. Payment instructions and fee rates will be outlined in the second level determination letter. This ends the appeal process.

Medical records

Medical records

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

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, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts for 10 years from date of service.

The provider shall give without limitation, Blue Cross Blue Shield of Michigan, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation, maintained by the provider, which will be consistent with all federal, state and local laws. Such records will be used by CMS and Blue Cross to assess compliance with standards which includes, but not limited to:

- Complaints from members and/or providers
- Conduct HEDIS reviews, quality studies/audits or medical record review audits
- 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
- Medical Management specific medical record reviews
- Suspicion of fraud, waste and/or abuse

- Periodic office visits for contracting purposes
- Other reviews deemed appropriate and/or necessary

Medical record content and requirements for practitioners

(See below for behavioral health practitioner requirements.)

Content and requirements include, but may not be limited to:

Clinical record

Patient name, identification number (**name and ID number must be on each page**), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.

Medical documentation

History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services and other risk screening.

- Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes discussing medical, surgical, social and behavioral history, as well as chronic conditions, family history, medications, allergies and immunizations. The provider will perform a baseline physical assessment, age- and sex-specific risk-screening exam, relevant review of systems, and depression and alcohol screening.
- Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.

Clinical record – progress notes

Identification of all providers participating in the member's care and information on services furnished by these providers.

Reason for visit or 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 and follow-up report to referring practitioner (if applicable).

Clinical record — reports content

Reports must be reviewed, signed and dated within 30 days of the service or event:

- Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from health care delivery

organizations, such as skilled nursing facilities, home health care, free-standing surgical centers, and urgent care centers.

Medical record content and requirements for behavioral health practitioners:

Content and requirements include, but may not be limited to:

- 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, that describes each of the items below:
    - Speech
    - Thought processes
    - Associations (such as loose, tangential, circumstantial, or intact)
    - Abnormal or psychotic thoughts
    - 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 Diagnostic and Statistical Manual of Mental Disorders 4 (DSM-IV) diagnosis, consistent with the presenting problems, history, mental status examination and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member's acceptance of the treatment goals. Formal signed consent is not required except where required by law.
- To ensure coordination of the member's care, the treatment records shall reflect continuity and coordination of care with the member's primary care practitioner and as applicable; consultants, ancillary

practitioners and health care institutions involved in the member's care.

- Where it is required by law, obtain proper documented written and signed consent for any release of information to outside entities.
- 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.

Other medical record 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 stationery) for each date of service.

CMS prohibits the use of stamped signatures on any medical record. Acceptable signatures include handwritten (initials can be used if the full name and credentials appear somewhere in the record or on stationery) or an 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 practitioner's name, credentials, date and signature).

Providers must include their specialty credentials when providing their signature. In addition, CMS requires that signatures be legible. CMS does not accept a signature that cannot be readily identified. All entries in the clinical record must be legible, dated and contain author identification.

Electronic submission

In mid-December 2024, Blue Cross expanded the ability to upload medical records through our provider portal, Availity Essentials™. For Medicare Plus Blue members, providers can upload medical records for these reasons:

- Claims denied with an EX code indicating that the medical record is required.
- Original electronic claim 837 transaction that requires medical records. This option will be available the day after you submit the claim.

Providers can submit the medical records using the Send Attachments feature, which is available on the Claim Status screen in Availity Essentials. For step-by-step instructions, and to learn how to access recorded training, see the Medical records: Submit electronically through Availity Essentials document.

Medical record audits and reviews

All records related to services rendered to Medicare Plus Blue PPO members can be audited and/or reviewed during the term of the provider's Medicare Advantage PPO 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. Providers who do not respond to an audit request in the allotted timeframe can have their entire claim or service denied as not containing sufficient documentation to demonstrate the services were reasonable or necessary. In these situations, you can follow the two-step appeal process as outlined in this manual. We will not use medical record reviews to create artificial barriers that would delay or deny rightful payments to providers.

Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements. Only when a member has paid for the full cost of services out-of-pocket will an authorization for release of information be required.

Retroactive audits and appeals

Blue Cross conducts audits in accordance with Medicare laws, rules and regulations. We will conduct audits as needed, including, but not limited to Diagnosis Related Group coding and clinical validation audits, site of care reviews, readmission audits, audits at skilled nursing facilities, inpatient rehabilitation facilities, home health care or other network providers, practitioners and suppliers, CMS risk-adjustment validation audits and Blue Cross risk-adjustment medical reviews. The presence of a prior authorization for a service or stay does not exempt the record or related claims from retroactive audits or documentation requirements (i.e., a valid inpatient order signed by a qualified provider prior to discharge of the patient as defined by CMS regulatory guidance). The lack of a valid inpatient order will result in a claim denial.

Additionally, prior authorization of services is not a guarantee that claims will be paid as billed. We may conduct audits on services to determine that care provided was delivered and billed in the most appropriate, reasonable, and cost-effective setting available. We may also conduct audits to assure that claims billing matches services actually provided according to claims payment rules and regulations. Blue Cross contracted providers and practitioners will be required to submit medical records for these audits.

CMS risk-adjustment validation audits

CMS makes advance monthly payments to Medicare Plus Blue PPO plans for providing coverage of Original Medicare fee-for-service benefits for each individual enrolled in a Medicare Plus Blue PPO plan per month. CMS may require Medicare Advantage organizations and their providers to submit medical records for the validation of risk adjustment data. There may be penalties for submission of false data.

Section 1853(a)(3) of the Social Security Act requires that CMS risk adjust payments to Medicare Advantage organizations. In general, the current risk adjustment methodology relies on member diagnoses, to

prospectively adjust capitation payments for a given member based on the health status of the member. Diagnosis codes submitted by MA organizations are used to determine beneficiary risk scores, which in turn determine the risk-adjusted reimbursement.

RADV audits determine whether the diagnosis codes submitted by MA organizations can be validated by supporting medical record documentation. This medical record documentation must meet certain criteria and standards as specified by CMS. Blue Cross may contract with a vendor to perform these reviews. All vendors are required to have a Business Associate Agreement with Blue Cross and are required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Blue Cross risk-adjustment medical record reviews

From time to time, Blue Cross will require providers to make records available for on-site review or submission to ensure claims submitted are consistent with the chronic conditions documented in members' medical record. Blue Cross may contract with a vendor to perform these reviews. All vendors are required to have a Business Associate Agreement with Blue Cross and are required to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996.

Blue Cross reimburses $5 for each individual chart from a provider's office and $5 per care episode at hospital facilities. Download a reimbursement form here. You may fax the form including your invoice to us at **1-972-957-2143**. Most requests are processed within 30 to 45 business days.

Blue Cross will not reimburse for copy house services. If a provider or an accountable care organization contracts with a copy house vendor, they will be responsible for reimbursing that vendor.

HEDIS medical record reviews

Blue Cross collects medical record data for HEDIS at certain times of the year for quality improvement initiatives. Medical record reviews may require data collection on services obtained over multiple years. Archived medical records/data may be required to complete data collection.

For HEDIS reviews, we collect details that may not have been captured in claims data, such as blood pressure readings, lab services, breast cancer and colorectal cancer screenings, diabetic eye exam screenings and admission and discharge documentation. This information helps us enhance member quality improvement initiatives.

A Blue Cross employee or designated vendor(s) will collect the requested HEDIS documentation. Provider offices are responsible for returning the documentation requested in a timely manner, if possible, within 7 days of the request. Blue Cross or its designated vendor(s) will contact your office to establish a date for an onsite visit or the option to fax or mail the data

requested or provide remote EMR access. A patient list will be sent including the name and information being requested.

If your office prefers an onsite visit, please have the medical records available ahead of time. If a chart for a patient is being requested and not available at your practice location, you should notify the Blue Cross employee or the designated vendor immediately.

We request that providers allow Blue Cross employees or its designated vendor(s) to scan the medical records during an onsite visit. HEDIS requires proof of service for any data that is collected from a medical record.

Other Medicare Plus Blue PPO requirements

Settlements

Hospital Settlement

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/ Administrative Contractor will attempt to make the interim payments as accurate as possible.

After the hospital's fiscal year end, the fiscal intermediary settles with the providers for the difference between interim payments and actual reasonable costs.

CMS policy does not require plans to agree to settle with providers. Blue Cross conducts settlements on hospital claims for Blue Cross Medicare Advantage PPO members, when requested, where certain provisions of the Original Medicare reimbursement system are not accounted for through the normal claims vouchering system (for example, disproportionate share, bad debt, capital for a new hospital for first two years, etc.) Bad debt and critical access hospital settlements include both inpatient and outpatient claims for Medicare Advantage PPO members. All other outpatient reimbursement issues should be referred to your Blue Cross provider consultant.

To minimize financial impact of the settlement and to ensure proper reimbursement throughout the year, hospitals are expected to retrieve their current year rates from the Fiscal Intermediary/MAC and submit their rate letter (or system equivalent) to MARateLetterSubmissions@bcbsm.com.

Blue Cross conducts settlements on a hospital's full fiscal year at the appropriate Medicare rate based on discharge date. Blue Cross reviews the Medicare Cost Report, the specific claims submitted for review, and the interim rate letters to determine the cost settlement.

The hospital must request a settlement from Blue Cross in writing within 180 days of the hospital's fiscal year-end, and must include all of the following information:

- 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 (or system equivalent) for the applicable time period
    - A detailed Blue Cross claims list (a template will be provided)
    - Calculations showing how the impact amount was determined

Blue Cross reviews the information and gives a written determination of funds owed the provider from Blue Cross or funds owed Blue Cross from the provider. Payment of the settlement will be due by either party, starting 60 days after final terms of the settlement are agreed upon.

Blue Cross reimburses Bad Debt claims for only uncollected Medicare Advantage PPO member liability. Charges for non-covered services are not included. The hospital must provide a signed attestation that it defines and calculates its bad debt numbers in accordance with the CMS rules and guidelines. The Blue Cross MA PPO bad debt claims template, along with the attestation, are provided upon receipt of the request for settlement.

Blue Cross pays Critical Access Hospital claims on an interim basis using the per diems and percentage of charges stipulated in the Fiscal Intermediary/MAC interim rate letter applicable to the date on which services are rendered. The cost-based reimbursement rate and elected payment method used for the year under review are compared to the rate calculated on the Medicare Cost Report and a settlement is made based on the difference. Once a hospital elects to engage in the settlement process, all subsequent years will need to be settled.

Federally Qualified Health Centers Vaccine Settlement

Effective Oct. 1, 2014, CMS changed the payment system for Federally Qualified Health Centers from an "all-inclusive rate" system to a prospective payment system. Blue Cross Blue Shield transitioned FQHCs to the PPS based on their cost reporting periods beginning Nov. 1, 2015. As a result of this change, FQHC's will be compensated for flu and pneumococcal vaccines by Blue Cross through an annual settlement process.

FQHCs should continue to bill pneumococcal and flu vaccines as this information will be used at the end of the fiscal year to determine the settlement amounts. Settlement requests must be sent to fqhcsettlementrequests@bcbsm.com within 180 days of the fiscal year

end to be eligible. Settlements will be conducted only on a complete fiscal year and only for claims that have been billed. The settlement calculations are made using the CMS Average Sale Price fee schedule.

If you would like further information on the vaccine settlement process, please email your question(s) to fqhcsettlementrequests@bcbsm.com.

Annual Physical Settlements

Blue Cross will compensate FQHCs for annual physicals through an annual settlement process. The payment system is not configured to pay individual claim lines on FQHC claims.

FQHC providers should continue to bill annual physical services on their UB-04 claim form for tracking purposes, as this information will be used at the end of the fiscal year to determine the settlement amounts.

Settlement requests must be sent to fqhcsettlementrequests@bcbsm.com within 180 days of the fiscal year end to be eligible. Settlements will be conducted only on a complete fiscal year and only for claims that have been billed. If you would like further information on the annual physical settlement process, please email your questions to fqhcsettlementrequests@bcbsm.com.

Serious adverse events and present on admission

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

Serious adverse events are conditions resulting from medical errors in the hospital or improper hospital care that are reasonably preventable. These events are classified into two categories based on degree of error:

- Never event – an event that should absolutely never, under any circumstance, occur in a hospital, such as performing surgery on the wrong patient
- Treatment-induced medically necessary event – an event caused by errors that becomes medically necessary to treat, such as catheter-associated urinary tract infections

The main provisions of the policy are as follows:

- Blue Cross will no longer reimburse a hospital or physician whose direct actions result in a serious adverse event.
- Serious adverse events affected by this policy will be updated as needed to remain consistent with changes made by the Center for Medicare & Medicaid Services.

- Blue Cross participating hospitals are required to report present on admission indicators on all claims. Refer to CMS' coding webpage** for more information.
- Blue Cross participating hospitals are not to balance bill members for any incremental costs associated with the treatment of a serious adverse event that Blue Cross has paid.
- Blue Cross members who have been billed in error should report incidents to Blue Cross 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 Blue Cross participating hospital agreement.

To administer the SAE policy, Blue Cross and BCN developed a list of non-reimbursable serious adverse events (also known as hospital-acquired conditions, or HACs). The list below contains examples of the most common serious adverse events; it is not intended to be an all-inclusive list.

- Foreign object left in the body after surgery
- Air embolism
- Blood incompatibility
- Catheter-associated urinary tract infection (UTI)
- Pressure sores (decubitus ulcers) — Stage 3 or 4
- Vascular catheter-associated infection
- Surgical site infections following:
    - Mediastinitis following a coronary artery bypass graft surgery
    - Gastric bypass
    - Certain orthopedic procedures
    - Cardiac Implantable Electronic Device
- Falls and trauma
    - Fractures
    - Dislocations
    - Intracranial and crushing injury
    - Burns
    - Other injuries
- Deep vein thrombosis or pulmonary embolism following certain orthopedic procedures

- Manifestations of poor glycemic control
- Iatrogenic pneumothorax with venous catheterization

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

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

Note: For more conditions included in the SAE policy, see the CMS' ICD-10 HAC list.**

Hospitals participating with Blue Cross are required to submit present-on-admission indicator information for all primary and secondary diagnoses, for both paper and electronic claims.

The POA indicator is used to identify conditions present at the time the admission occurs, including those that develop during an outpatient encounter in settings that include the emergency department, observation or outpatient surgery. The POA indicator is not required on secondary claims.

The following values, established by CMS, should be used to indicate POA when submitting data:

Value	Definition
Y	Diagnosis was present at the time of inpatient admission
N	Diagnosis was not present at the time of inpatient admission
U	Documentation is insufficient to determine whether the condition was present at the time of inpatient admission
W	Clinically undetermined. Provider is unable to determine clinically whether the condition was present at the time of inpatient admission

Value	Definition
1	• Unreported /not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04; however, it was determined that blanks are undesirable when submitting this data via the 4010A. • Will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list. For a complete list of codes on the POA exempt list, see page 110 of the Official Coding Guidelines for ICD. See the *ICD Official Guidelines for Coding and Reporting*.**

POA claim filing information

The POA data element on the electronic claim must contain the letters "POA," followed by a single POA indicator for every diagnosis you report. The POA indicator for the principal diagnosis should be the first indicator after "POA," followed by (when applicable) the POA indicators for the secondary diagnoses. The last POA indicator must be followed by the letter Z to indicate the end of the data element.

When filing UB-04 paper claims, the POA indicator should be reported as the eighth digit of the principal diagnosis field in form locator 67 and the eighth digit of each of the secondary diagnosis fields in form locator 67, A-Q.

POA exemptions

Certain categories and conditions are exempt from POA reporting because they:

- Represent circumstances regarding the health care encounter or factors influencing health status that do not represent a current disease or injury
- Are always present on admission

The policy on serious adverse events is administered as follows:

- **For DRG-reimbursed hospitals** — Blue Cross uses the Medicare severity diagnosis-related groups (MS-DRG).
- When the member is readmitted to the same hospital and the admissions are combined — Hospitals should follow the current process for combining admissions:
    - If the POA indicator is correctly reported as Y (indicating the condition was present on admission), there is no financial reduction.

  - In cases in which the POA for the serious adverse event was N (indicating that the condition was not present on admission and that, therefore, the readmission was a direct result of the serious adverse event), the two cases are combined and only the first admission is reimbursed.

- **When the member is readmitted to the same hospital and the admissions are not combined** — Any readmission with diagnosis associated with a serious adverse event during the initial admission may be selected for audit review to validate its presence on admission.
- **When the member is admitted to a different hospital** — When an admission to a second hospital carries a POA indicator of Y but the treatment is that which is medically necessary to treat the adverse event, the second hospital is held harmless and is reimbursed for the admission.
- **When claims are submitted with an invalid POA** — Claims submitted with an invalid POA indicator are returned to the hospital for correction and are not entered into the Blue Cross claims system.
- **When treatment to correct the adverse event is rendered by a hospital or physician not responsible for the adverse event** — In all cases, the second hospital and the second physician correcting the adverse event are held harmless. Because the treatment is medically necessary, they are reimbursed.

Clinical research studies

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. **Therefore, providers must submit claims for Medicare-covered services related to the clinical trial to carriers and fiscal intermediaries**, not to Blue Cross, using the proper modifiers and diagnoses codes. Medicare-covered services not affiliated with clinical trials must be billed to Blue Cross, and Blue Cross will reimburse providers accordingly.

Investigational Device Exemption (IDE) Studies

Medicare Plus Blue will pay for routine care items and services in CMS-approved Category A and Category B IDE studies, as well as CMS-approved Category B devices. For Medicare Plus Blue members enrolled in in CMS-approved Category A and Category B IDE studies, submit claims for routine care items and services, and CMS-approved Category B devices, to Blue Cross. CMS will not approve Category A devices because they are statutorily excluded from coverage.

Clinical Studies Approved Under CED

As an MAO, Blue Cross is responsible for payment of items and services provided to Medicare Plus Blue members in CMS-approved CED studies unless CMS determines that the significant cost threshold is exceeded for that item or service.

Swing beds

Swing beds in a critical access hospital are paid according to the critical access hospital methodology (101 percent of cost). We follow CMS guidelines. See CMS' MLN Fact Sheet on *Swing Bed Services*.**

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

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

Qualifications and requirements

To be included in Blue Cross Medicare Advantage network, providers must:

- Have a national provider identifier they use to submit electronic transactions to Blue Cross (in accordance with HIPAA requirements) or to submit paper claims to Blue Cross.
- Meet all applicable licensure requirements in the state of Michigan and meet Blue Cross credentialing requirements pertaining to licensure.
- Furnish services to a Medicare Plus Blue 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 Blue Cross.
- Agree to bill us for covered services provided to Medicare Plus Blue members.
- Accept our reimbursement as full payment less any member cost sharing.
- Receive payment directly from Blue Cross.
- Not be on the CMS preclusion list or U.S. Department of Health and Human Services Office of Inspector 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 Blue Cross 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 appeal 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 stinting, bariatric surgery, PET scans for oncology, or lung volume reduction). The list of special services will be automatically updated as determined by CMS.
- Be in good standing with Blue Cross and meet and maintain all Blue Cross credentialing requirements for network inclusion. Examples of being in good standing are:
    - Unrestricted license to practice
    - No license limitations
    - Not on prepayment utilization review, not in the performance monitoring program or not de-participated from the Traditional program
    - Not denied or disaffiliated from the TRUST program within a two-year period of application to Medicare Advantage PPO

  - No Medicare or Medicaid preclusion, exclusion, sanction, or debarment
  - Not opting out of Medicare
- Agree to accept all Medicare Plus Blue PPO members unless practice is closed to all new patients (commercial or Medicare).
- Have submitted claims within the last 24 months. We'll disenroll providers who don't submit claims for 24 consecutive months because we must maintain accurate and current provider data as required by CMS, NCQA and other regulatory and legislative bodies.

Participation agreements

The Medicare Advantage PPO Provider Agreement includes a base agreement that applies to all providers and attachments specific to certain provider types which may be accessed on our website:

- Blue Cross Medicare Advantage PPO Provider Agreement
- Blue Cross 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 Attachment

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 Blue Cross 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 PPO 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 Blue Cross Medicare Advantage PPO contract. These members will receive in-network benefits in accordance with their member contract. There is potential for members of other Blue plans to read and write reviews about their patient experience.

If you are not a contracted Medicare Advantage PPO provider for Medicare Plus Blue 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, including renal dialysis services provided while the member was temporarily outside the plan's service area, will be reimbursed at the out-of-network benefit level.

The Blue Cross Blue Shield Association mandates that all Association members require all participating providers to be responsible for obtaining pre-service reviews for inpatient facility services provided to Medicare Advantage members from other states. Keep the following guidelines in mind:

- Obtain pre-service reviews prior to admission for inpatient facility services when such a review is required under the member's plan.
- Out-of-state members will be held harmless if a pre-service review is required and not performed prior to admission for inpatient facility services. You cannot bill or collect from a member for covered services where you failed to perform pre-service review as required.
- Specified time frames for pre-service review may apply. These include: 48 hours to notify the host plan of a change in the pre-service review and 72 hours in the case of an emergency or urgent care notification.

Providers can use the Electronic Provider Access tool to determine whether pre-service is required. The tool allows you access to other Blue plan provider portals for the purpose of conducting pre-service reviews.

Affiliation

Professional and facility enrollment

Information on joining our network is available at bcbsm.com/providers/network. Visit our Provider enrollment webpage for professional and facility provider classifications and required documents.

Affiliation requirements

Hospitals and facilities

Facilities must meet certain requirements to participate in the Medicare Advantage PPO network. These requirements are available on the Provider enrollment webpage.

Outpatient physical therapy facilities

Physical therapy practice locations must not be associated with both a group practice *and* an OPT facility. If a practice location is found to be listed for both a group practice and an OPT facility, the practice location will automatically be removed from the group.

Physicians and professionals

Practitioners who request affiliation in the Medicare Advantage PPO Network must meet specific network requirements. These requirements are available on the Provider enrollment webpage. They must also complete an online application on the Council for Affordable Quality Health Care Universal Credentialing Datasource website. 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 recredential network practitioners.

Blue Cross registered — must be or become registered with Blue Cross and have an active identification number. To become registered, go to bcbsm.com/providers 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 (the board must be one recognized by Blue Cross, such as the American Board of Medical Specialties) at the time of credentialing, and maintain board certification throughout affiliation. (Exception: Current Blue Cross 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 preclusions, 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 Blue Cross prepayment utilization review program will be denied affiliation with the Medicare Advantage PPO network.

Blue Cross departicipation — An applicant with a current or significant history of formal departicipation action by Blue Cross 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 for high volume specialties is in excess of $500,000 within a five-year period and the screening criteria for other specialties is in excess of $200,000 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 recredentialing review and decision-making, such as:

- Data Bank (National Practitioner – Healthcare Integrity and Protection) findings
- No history of conduct that threatens patient safety or adversely affects Blue Cross' 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 Blue Cross 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).
- Update facility and organizational provider information in the **Provider Data Management** tool within Availity Essentials. Per the Consolidated Appropriations Act, providers must update and attest to the accuracy of their provider directory data every 90 days — even if no changes are needed. Failure to complete the quarterly attestation will result in being removed from our provider directory and may affect our ability to process claims on your behalf. For more information about attestation, see the Provider Data Attestation page on bcbsm.com.
- Professional practitioners, including those who practice at an office location or exclusively in an inpatient hospital setting: Complete attestation in the CAQH Provider Data Portal (formerly known as CAQH ProView®) every 90 and 120 days as follows:

Frequency	What to do
Every 90 days	Attest to the following data elements: name, specialty, address, phone number and digital contact information. Attestation is a requirement of the Consolidated Appropriations Act, even if no changes are needed.
Every 120 days	Attest to all other data elements. This includes elements related to credentialing, licensing and elements other than those listed in the previous section. **Note:** If you fail to attest, your credentialing status will end, and you'll need to reapply.

Online provider search

In general, information on credentialed Medicare Plus Blue contracted providers appears in online provider searches. Online provider search results list professional providers according to their primary specialty they

identified during the application process, as well as all the specialties indicated in their CAQH Provider Data Portal application that are verified during credentialing. Medicare Plus Blue members can also find the following information for providers in the online search:

- Treatment cost estimates for certain services
- Quality data
- Office hours
- Patient reviews, including ratings and comments

Online provider search results allow Medicare Plus Blue members and members from other Blue plans to comment about and evaluate care received from providers. This is helpful for patients when making healthcare decisions and is a source of valuable feedback for providers.

Locum tenens practitioners

A locum tenens practitioner is hired to deliver medical care on a temporary basis for up to 60 continuous days in the office of a practitioner who is contracted with Medicare Plus Blue but who is unavailable due to illness, pregnancy, vacation or participation in continuing medical education. This arrangement is intended to ensure coverage for Medicare Plus Blue members in the absence of a contracted practitioner.

A covering or on-call practitioner must be Medicare certified and have a specialty the same as or similar to that of the contracted practitioner.

A locum tenens practitioner who treats Medicare Plus Blue members for more than 60 continuous days must register with Blue Cross, undergo formal credentialing and bill under his or her own NPI. Failure to do so will result in Blue Cross applying out-of-network sanctions on claims, up to and including denial, for members whose coverage doesn't provide for out-of-network services.

Requirements for locum tenens practitioners

- Have a current valid state license or interstate medical licensure compact or temporary "military spouse" Michigan health profession license.

Note: During national emergencies or pandemic crises declared by the federal government or during state emergencies or pandemic crises, if directed by federal or state authorities or both, Blue Cross will allow licensed practitioners to provide services to Blue Cross members outside of their state-of-provider licensure. Blue Cross will temporarily waive the requirement that non-Michigan practitioners be licensed in Michigan, where they are providing services, when they are licensed in another state. This will occur until the statewide emergency has been lifted.

- Maintain and make available upon request the following:

- Documentation addressing contractual arrangements, licensure and malpractice insurance between the locum tenens practitioner and the contracted practitioner
- A record of all clinical services provided by the locum tenens practitioner

Billing for services provided by a locum tenens practitioner

Each covered clinical service (procedure code) provided by the locum tenens practitioner under the contracted practitioner's NPI must be appended with one of the following modifiers:

- Modifier Q5: Service furnished under a reciprocal billing arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy services
- Modifier Q6: Services furnished under a fee-for-time compensation arrangement by a substitute physician; or by a substitute physical therapist furnishing outpatient physical therapy

The contracted practitioner must pay the locum tenens practitioner a per-diem or agreed-upon amount; the locum tenens practitioner must not independently bill Blue Cross / BCN for the services.

When a contracted practitioner leaves a group, the services of the locum tenens practitioner may be billed for up to 60 days using either the replaced practitioner's NPI or the group NPI.

Disaffiliation

Voluntary vs. involuntary disaffiliation

The Blue Cross Medicare Advantage PPO Provider Agreement can be terminated by Blue Cross or an affiliated provider, in accordance with the terms of the 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 either party at any time, except during the initial term of the Agreement, with 60 days written notice to Blue Cross or as otherwise provided in the Agreement.

Involuntary — Initiated by Blue Cross in accordance with the terms of the Agreement and applicable internal policies. Depending on the reason(s) for this type of disaffiliation, you may be able to re-apply for affiliation two years after the disaffiliation date.

Obligations of recipients of federal funds

Obligations

Providers participating in Medicare Plus Blue PPO are paid for their services with federal funds and must comply with all requirements of laws applicable to recipients of federal funds, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, the False Claims Act (32 USC 3729, et seq.) and the Anti-kickback Statute (section 128B(b) of the Social Security Act).

Blue Cross is prohibited from issuing payment to a provider or entity that appears on the List of Excluded Individuals/Entities as published by the U.S. Department of Health and Human Services Office of Inspector General, the list of debarred contractors as published by the U.S. General Services Administration, or the CMS preclusion list (with the possible exception of payment for emergency services under certain circumstances).

Providers can access additional information as follows:

- The Department of Health and Human Services Office of the Inspector General List of Excluded Individuals / Entities can be found at exclusions.oig.hhs.gov/.**
- The General Services Administration list of debarred contractors can be found at sam.gov** in the System for Award Management.

For more information on the CMS preclusion list, see "*CMS preclusion list*" on page 6 of this manual.

Fraud, waste and abuse

Detecting and preventing fraud, waste and abuse

Blue Cross is committed to detecting, mitigating and preventing fraud, waste and abuse. Providers are also responsible for exercising due diligence in the detection and prevention of fraud, waste and abuse as well, in accordance with the Blue Cross Detection of Fraud, Waste and Abuse policy.

Blue Cross encourages providers to report any suspected fraud, waste and/or abuse to the Blue Cross Corporate and Financial Investigations department, the corporate compliance officer, the Medicare compliance officer, or through the anti-fraud hotline, **1-800-482-3787**. The reports may be made anonymously.

What is fraud?

Fraud is determined by both intent and action and involves intentionally submitting false information in order to get money or a benefit payable under a federal health care program, like Medicare.

Examples of fraud include:

- Billing for services not rendered or provided to a member at no cost
- Upcoding services
- Falsifying certificates of medical necessity
- Knowingly double billing
- Unbundling services for additional payment

What if I suspect fraud? If you suspect fraud, please contact Blue Cross Blue Shield of Michigan Anti-Fraud Hotline at **1-888-650-8136** (24 hours a day/seven days a week).

What is waste?

Waste includes activities involving payment or an attempt to receive payment for items or services where there was no intent to deceive or misrepresent, but the outcome of poor or inefficient billing or treatment methods cause unnecessary costs.

Examples of waste include:

- Inaccurate claims data submission resulting in unnecessary rebilling or claims
- Prescribing a medication for 30 days with a refill when it is not known if the medication will be needed
- Overuse, underuse and ineffective use of services

What is abuse?

Abuse includes practices that result in unnecessary costs or reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Examples of abuse include:

- Providing and billing for excessive or unnecessary services
- Routinely waiving member coinsurance, copayments or deductibles
- Billing Medicare patients at a higher rate than non-Medicare patients

Required compliance training on Medicare fraud, waste and abuse

Blue Cross requires its Medicare providers to take specific training about fraud, waste and abuse and general compliance. Providers may complete the CMS training modules available at bcbsm.com/providers/help/medicare-fraud-training. Otherwise, providers may utilize their own training program as long as it contains content substantially similar to the CMS training modules.

Providers should make sure that governing body members and any employees (including volunteers and contractors) or contractors providing health or administrative services in connection with the Blue Cross Blue Shield of Michigan Medicare Advantage program complete the training

within 90 days of being hired and annually thereafter. Be sure to keep the certificate generated by the website as proof that you took the training and retain evidence of training for 10 years from the end date of your contract with Blue Cross. You need to be able to provide proof to Blue Cross or CMS if requested.

Medicare Part D program

As part of an ongoing effort to combat fraud, waste, and abuse in the Medicare Part D program, CMS' program integrity contractor, the NBI MEDIC (Health Integrity, LLC), requests prescriber prescription verifications. The NBI MEDIC routinely mails prescriber prescription verification forms containing the beneficiary's name, the name of the medication, the date prescribed, and the quantity given. The form also asks the prescriber to check yes or no to indicate whether the prescriber wrote the prescription. The prescriber is asked to respond within two weeks. If no response is received, then the investigator follows up with a second request.

A timely and complete response to prescription verification is important as it is likely to result in the elimination of an allegation of wrongdoing and/or prevent the payment of fraudulent prescriptions without need for further investigation.

Providers who are involved in the administration or delivery of the Medicare Part D prescription drug benefit are strongly encouraged to respond in a timely manner to prescription verifications when contacted by the NBI MEDIC.

Additionally, if you wish Part D to cover a prescription, you must have a valid NPI number and not be on a preclusion list.** CMS published a final rule on April 16, 2018 (CMS-4182-F):** Beginning in 2019, CMS rescinded the requirement that providers be enrolled in Medicare in order for their prescriptions to be coverable under the Medicare Part D program; however, the provider must not be on the preclusion list. Blue Cross Blue Shield of Michigan will reject an otherwise valid prescription if it was written by a prescriber who is on the preclusion list.

Repayment rule

If you've received an overpayment, don't return the check to us. We will recover overpayments by deducting them from future claim payments to you. We call this method of recovery an offset.

If you notice an overpayment, you can either call Provider Inquiry at **1-866-309-1719** or complete and send the Request for Offset form (PDF) to the email or street address on the form.

Give the following information about the overpayment:

- Patient's name
- Patient's contract number
- Date of service

- Claim number
- Claim line numbers
- Amount of overpayment
- Reason for the claim adjustment
- Fully complete the provider section on the form

Our Provider Inquiry representative will help determine if the payment was truly an error and advise you if and when the recovery process will begin.

If we receive an incomplete form, or if the information about your claim adjustment is unclear, we'll call you to make sure everything is accurate. If we're unable to reach you, we'll return the form by mail with a request for more information.

If we notice an overpayment, we'll adjust your claim. The amount due is collected from future payments. After 30 days, we'll send you a letter that details overpayments that were not recovered from future claim payments. You'll also receive a notice of claim overpayments that are outstanding after 60 days. After 60 days, you're required to make a payment.

After Blue Cross has exhausted all attempts to collect the debt, we'll refer Medicare Plus Blue claims with an outstanding account receivable aged beyond 180 days to GB Collects for debt collection. GB Collects, a commercial collection agency, will conduct provider outreach and coordinate receipt of payment on behalf of Blue Cross.

You have dispute rights if you believe that the amount to be recovered or the reason we give is incorrect. Please see the *Payment disputes* section of this manual for direction.

Questions, additional information and contacts

Contact information

Blue Cross does not prohibit network health care professionals from advising or advocating on behalf of patients.

For general questions about Medicare Plus Blue PPO:

Call Medicare Plus Blue Provider Inquiry at **1-866-309-1719.** An automated response system is available 24/7.

Or mail:

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

For DME-related questions, providers should contact Northwood.

For provider inquiries, call **1-800-393-6432** Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time.

Mail: P.O. Box 510
Warren, MI 48090-0510

Fax: 1-586-755-3733

Or, complete the provider application online at: northwoodinc.com.**

**Blue Cross maintains bcbsm.com and ereferrals.bcbsm.com. Blue Cross doesn't own or control any other websites referenced in this publication.

Availity® is an independent company that contracts with Blue Cross Blue Shield of Michigan and Blue Care Network to offer provider portal and electronic data interchange services.

Teladoc Health® is an independent company that provides virtual care solutions on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

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