Blue Cross complete of Michigan

Provider Manual

Blue Cross Complete of Michigan LLC is an independent licensee of the Blue Cross and Blue Shield Association

www.mibluecrosscomplete.com

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January 2024

Section 1: Introduction

A. Overview: Blue Cross Complete

What is Blue Cross Complete?

As of February 1, 2024, Blue Cross Blue Shield of Michigan and Independence Health Group, the parent companies of AmeriHealth Caritas, formalized a new ownership structure for Blue Cross Complete of Michigan. The new ownership structure reflects a 70/30 ownership arrangement with BCBSM owning 70% of Blue Cross Complete and IHG owning 30% of the Plan.

Blue Cross Complete is not contracting as the agent of the Association. No person, entity or organization other than Blue Cross Complete will be held accountable or liable for any of Blue Cross Complete's obligations created under the contract. Blue Cross Complete is solely responsible for its own debts and other obligations.

Blue Cross Complete is contracted with the Michigan Department of Health and Human Services to provide health care coverage to eligible Medicaid beneficiaries consistent with all applicable Medicaid policies and publications for coverages and limitation. If new Medicaid services are added, expanded, eliminated, or otherwise changed, Blue Cross Complete implements the changes.

Note: Blue Cross Complete enrolls eligible individuals into the Healthy Michigan Plan, which offers health care coverage to an expanded pool of Medicaid beneficiaries. This includes Adult Benefit Waiver beneficiaries. Providers may access additional information about who is eligible for this plan at **michigan.gov/healthymiplan**.

Blue Cross Complete provides administrative services and arranges for the provision of covered services to all Blue Cross Complete members within the Blue Cross Complete service area. Blue Cross Complete providers offer preventive and wellness care (for example, an annual physical exam) and Blue Cross Complete encourages the Medicaid population to use medical services for preventive care.

Blue Cross Complete, not Medicaid, is the payer for covered health services rendered to a Blue Cross Complete member.

Payments shall be made in accordance with the terms of the agreement between Blue Cross Complete and MDHHS.

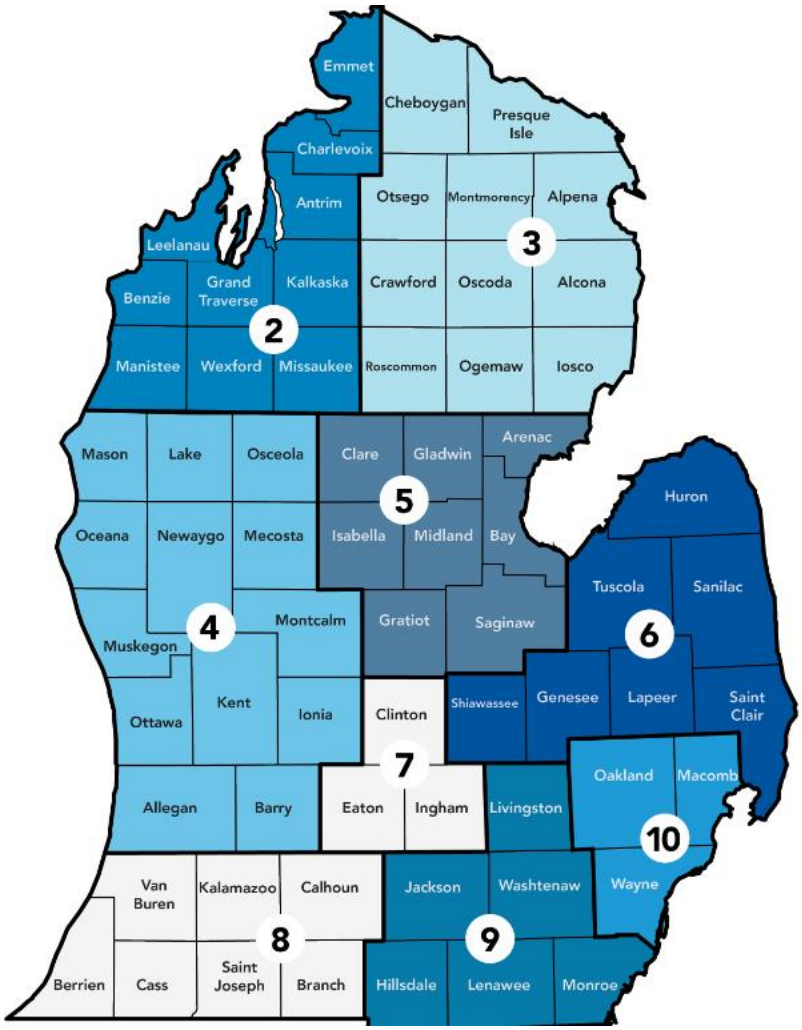
What Blue Cross Complete does

Blue Cross Complete of Michigan is a Medicaid managed care plan that contracts with physicians, hospitals and other health care providers to deliver care and provide service to Blue Cross Complete members.

In addition to providing basic health care coverage and customer services, Blue Cross Complete helps promote the delivery of high-quality care in a cost-effective manner by supporting the efforts of Blue Cross Complete-affiliated providers with programs such as care management and chronic condition management.

Blue Cross Complete geographic area

Blue Cross Complete services members in Michigan, in **regions 2, 3, 4, 5, 6, 9, 10** as shown below:



Blue Cross Complete mission

In support of the Blue Cross Blue Shield of Michigan mission to offer access to health care coverage to everyone regardless of circumstance, Blue Cross Complete will excel in providing health care coverage to Medicaid beneficiaries. Blue Cross Complete's commitment to this population is demonstrated by the provision of comprehensive and cost-effective coverage by Michigan's leading health insurance company.

Blue Cross Complete values

Blue Cross Complete's values are:

- Integrity and honesty
- Family and personal life
- Personal accountability and empowerment
- Helping and caring
- Quality and excellence
- Diversity and inclusiveness
- Community involvement

Blue Cross Complete confidentiality standards

Blue Cross Complete upholds the right to privacy of members and providers. All documents, data and knowledge of business and health care matters are maintained in a confidential manner, and strict standards are adhered to concerning the release of member or provider records and information. Blue Cross Complete employees may not discuss these matters with anyone outside the organization, except as may be required in the normal course of business, with appropriate authorization, or by law.

Blue Cross Complete educates members

Because knowledge is an important part of prevention, member education is vital to the Blue Cross Complete system of managed care. Blue Cross Complete educates members about managed care philosophy and health-related issues in various ways:

- Through **mibluecrosscomplete.com**, members can access valuable health information.
- *My Blue Health newsletter*, sent three times a year, contains information about benefits, advice on healthy self-care practices and the latest news about Blue Cross Complete programs.

B. How to use this manual

How to search the *Blue Cross Complete Provider Manual*

To search the manual, providers should complete the following steps:

1. Open the manual.
2. In the Edit menu, select *Search* or *Find*.
3. Enter the word or phrase that is being searched for.
4. Press *Enter*.

Blue Dot changes identify revisions to the manual

Edits to the *Blue Cross Complete Provider Manual* are identified as Blue Dot changes.

A cumulative list of all Blue Dot changes made during the year is available on **mibluecrosscomplete.com**.

Providers should watch for manual revisions and read the *Complete Update* and the *Blue Cross Complete provider news*, for the latest information.

C. Other electronic resources for providers

Blue Cross Complete's electronic systems

Providers are encouraged to use Blue Cross Complete's electronic systems to do business with Blue Cross Complete. Providers can sign up for access to the following electronic systems:

- NaviNet®, Blue Cross Complete's secure provider portal. Providers can use NaviNet to:
  - Verify a member's eligibility and benefits and see the history
  - Access the primary care provider panel roster and other reports
  - Check the status of claims
  - Submit and check the status of authorization requests
  - Access Care Gap reports for medical and pharmacy services

Providers who are not already NaviNet users can sign up at **navinet.navimedix.com** > **Sign up**.

- Blue Cross Blue Shield of Michigan Provider Secured Services Availity® provider portal. Providers can use Availity to:
  - Verify a member's Medicaid eligibility by selecting the appropriate payer in transaction dropdown and.entering their Medicaid ID number
  - Providers can sign up for Provider Secured Services and Availity at **bcbsm.com/providers**
- Optum/Change Healthcare:
  - Providers who have a software vendor or use another clearinghouse to submit claims to Optum/Change Healthcare will need to consult with their vendor/clearinghouse to see if there have been changes in their process for claims submission.
  - For questions contact Optum/Change Healthcare's call center at: **1-800-527-8133**, Monday through Friday from 8 a.m. to 8 p.m. CT.

Note: Providers must use their user ID within 14 days after they receive it. After that, providers are encouraged to log in to Availity monthly. Providers must log in at least once every six months to keep their account active. If the account becomes disabled or is no longer active, providers should call the Blue Cross Web Support Help Desk at 1-877-258-3932 to reactivate their account.

- Blue Cross Provider Enrollment and Change Self-Service (available only to practice group administrators for professional groups and allied providers)

Providers can also access additional information on Blue Cross Complete's public website at **mibluecrosscomplete.com**.

Other resources on the Web

Providers can also access the following resources online at **mibluecrosscomplete.com**:

- Blue Cross Complete Provider Manual
- Blue Cross Complete Provider Resource Guide At-a-Glance, a quick reference for phone and fax numbers
- Blue Cross Complete provider newsletter - *Connections*
- *Complete Update*, a bi-monthly publication that offers summaries of current Blue Cross Complete information

Each of these resources is an important source of information about doing business with Blue Cross Complete.

Forms

Providers can access Blue Cross Complete forms at **mibluecrosscomplete.com**.
The electronic version of a form can be saved to a computer hard drive and printed.
The forms are in Portable Document Format and opened with Adobe® Acrobat Reader®. A free copy of Acrobat Reader is available for download at **adobe.com**.

Providers who use the forms they download over time should check back periodically to make sure they have the latest version of the form. They should use the effective date or revision date of the form to determine whether they have the most current version. These dates are typically shown at the lower right on each page of the form.

For some of the forms, an interactive version is available. An interactive form can be opened using Adobe Reader version 7.0 or later, completed electronically, saved and printed. In some cases, the form can also be submitted electronically once it has been completed.

D. Provider communications

Blue Cross Complete providers receive an orientation

Blue Cross Complete providers receive a visit from a provider account executive who familiarizes them with things they'll need to know about Blue Cross Complete, including the following:

- Member ID card
- Checking eligibility and benefits
- Culturally and Linguistically Appropriate Services
- Information about the service area
- Contact phone numbers
- Drug coverage
- Utilization management requirements and systems (NaviNet Medical Authorizations)
- Member transportation resources
- Submitting claims

Providers receive information in other ways

Providers also receive updates on Blue Cross Complete information through the following:

- NaviNet
- Blue Cross Complete *Provider Manual*
- Blue Cross Complete Provider Newsletter - *Connections*
- *Complete Update*, a one-page summary of information pertinent to Blue Cross Complete providers published every other month
- Training for providers and their office staff by provider account executives

Providers can contact Provider Inquiry

Providers can contact Blue Cross Complete Provider Inquiry for assistance. Blue Cross Complete Provider Inquiry hours are 8 a.m. to 5 p.m., Monday through Friday.

The Blue Cross Complete Provider Inquiry phone and fax numbers are:

- Phone: 1-888-312-5713
- Fax: 1-888-987-6395

Providers should be ready to supply the following information when calling Provider Inquiry:

- Caller's name and direct phone number
- Provider's NPI
- Member's contract number, name and date of birth
- The information being requested

E. Assistance in working with Blue Cross Complete

Providers can request assistance through provider outreach

Providers may request individual assistance by calling their Blue Cross Complete provider account executive. The Blue Cross Complete provider account executive can help with the following:

- Enrollment and credentialing questions
- Contractual issues
- Recurring or unresolved problems
- Education and training on Blue Cross Complete policies, procedures and programs
- Discussion of medical care group administration
- Changes in primary care physician acceptance codes
- Requests for coverage / on-call providers

Section 2: System of Managed Care

A. Blue Cross Complete provider network

What is the Blue Cross Complete provider network?

The Blue Cross Complete provider network includes primary care physicians, specialists, hospitals and providers who are licensed or certified by the state of Michigan and authorized to provide Medicaid health care services.

Providers who wish to enroll in the Blue Cross Complete provider network should complete the appropriate Blue Cross Complete enrollment form (for practitioners or facilities), located at **mibluecrosscomplete.com**, under the "Change and Enrollment Forms" heading. Submit the form according to the instructions outlined on the form. Providers may call Blue Cross Complete Provider Inquiry at 1-888-312-5713 with any questions.

All providers furnishing services to Michigan Medicaid beneficiaries, including providers participating in a managed care organization's provider network, are required to be screened and enrolled in the Michigan Medicaid program. The State of Michigan's Community Health Automated Medicaid Processing System is the state's web-based Medicaid enrollment and billing system.

MDHHS prohibits Blue Cross Complete from making payments to all typical rendering, referring, ordering and attending providers not enrolled in CHAMPS.

This requirement applies to all individuals who provide services of any type to Medicaid beneficiaries, including but not limited to, health care providers, social services workers, pharmacies, and even family members who provide home care services to Medicaid recipients. This requirement also applies to those providers who do not bill directly to Medicaid Fee-for-Service but receive payment through a Medicaid managed care plan. For instructions on how to enroll in CHAMPS, log on to michigan.gov/medicaidproviders > **Provider Enrollment.** Providers who have questions about affiliation with Blue Cross Complete or about coordinating the care of a patient within the Blue Cross Complete network should contact their Blue Cross Complete provider account executive.

How to access information about the Blue Cross Complete provider network

Information on all providers in the Blue Cross Complete provider network can be accessed through the following:

- The online Blue Cross Complete provider search at **mibluecrosscomplete.com** > Find a Doctor.
- Blue Cross Complete Provider Inquiry at 1-888-312-5713 between 8 a.m. and 5 p.m., Monday through Friday

Mental health services are provided through the network

- Mental health services are provided through the Blue Cross Complete mental health provider network.

Note: Treatment for substance use disorders is not covered by Blue Cross Complete. Members must contact the Substance use Disorder Coordinating Agency for their county.

- Blue Cross Complete covers unlimited outpatient mild to moderate mental health intervention services and treatment. There are no referrals or authorizations required.

Members who have severe and persistent mental illness should contact their local PHIP in their county located at **Michigan.gov/mdhhs.**

Note: The Michigan Department of Health and Human Services has made available a standard consent form for sharing behavioral health and substance abuse treatment information. Here is some additional information about this form:

- The form complies with Public Act 129 of 2014.
- Although providers are not required to use this form, they are required to accept it.

Providers should visit **michigan.gov** to access the MDHHS-5515 behavioral health consent form and to read more about it.

Telemedicine services

Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid enrolled health care professional in a different location.

Blue Cross Complete covers telemedicine visits for our members in accordance with state and federal policy. To provide telemedicine services, practitioners must use technology that meet the needs for audio and visual compliance in accordance with state and federal standards. Practitioners must also ensure the privacy of the beneficiary and the security of any information shared via telemedicine.

Allowable telemedicine services are limited to those listed on the Michigan Medicaid telehealth fee schedule. For additional details regarding telemedicine including billing and reimbursement, visit michigan.gov.

Blue Cross Complete also includes telehealth services for our members through MDLIVE.

Providers interested in becoming a telehealth provider through MDLIVE should visit mdlive.com/provider for more information. **Note:** standard data and messaging fees may apply.

Note: MDHHS requires either direct or indirect patient consent for all services provided via telemedicine. Consent must be properly documented in the member's medical record in accordance with section 16284 of State of Michigan Public Act No. 359.

PerformRx is the pharmacy benefit manager

PerformRx, the pharmacy benefit manager for Blue Cross Complete:

- Processes prescription claims
- Manages the Blue Cross Complete Clinical Pharmacy Help Desk
- Provides coverage reviews for prior authorization after normal business hours

Blue Cross Complete network of laboratory vendors for outpatient laboratory services, DME and diabetic supplies

The table below shows the vendors preferred by Blue Cross Complete that provide covered services involving outpatient laboratory services; durable medical equipment / prosthetics and orthotics; and diabetic supplies for providers affiliated with Blue Cross Complete.

Type of service (outpatient/nonpatient)	Vendors
Laboratory	**JVHL** provides statewide network and third-party administration for outpatient laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims. **Quest Diagnostics** provides statewide outpatient laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims. **Drugscan** provides statewide outpatient clinical laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims.
DME, P&O and nondiabetic medical supplies	**Northwood, Inc**., which provides the statewide network and third-party administration for most DME and P&O covered services and is contracted by Blue Cross Complete to authorize and pay for all DME and P&O covered services. Note: As a general rule, outpatient diabetic supplies are not provided through the Northwood network.
Diabetic and incontinence supplies	**J&B Medical Supply**, which provides the statewide network for outpatient diabetic supplies

Providers should use Blue Cross Complete's network of laboratory vendors, when possible

Here are Blue Cross Complete's guidelines related to vendors:

- Providers should use Blue Cross Complete's network of laboratory vendors, when possible.
- Providers should refrain from referring members to vendor providers who are not contracted with Blue Cross Complete, including those who operate exclusively outside of Michigan.

Providers who feel that a Blue Cross Complete-contracted vendor cannot meet a need should contact the vendor or call the Blue Cross Complete Utilization Management department at 1-888-312-5713 (press 1) to submit a request for a service provided by a non-contracted vendor. This should occur prior to the service being rendered, unless it is an emergency.

Members may arrange for transportation

Blue Cross Complete members may arrange for transportation for medically and non-emergency medical transportation for any Medicaid-covered services. These services can include routine doctor visits; trips to specialty behavioral health services; including substance use disorder, necessary medical exams and treatment, prescriptions and durable medical equipment pickups, and dental appointments.

Members should arrange transportation in advance of their appointment. Patients who are pregnant or have a need for an urgent appointment can obtain same day transportation. Patients can arrange for transportation for appointments that are scheduled for multiple days with just one phone call. They can consult their Blue Cross Complete Member Handbook for more specific information on this requirement. Additional information on transportation services for Blue Cross Complete members is found at the following locations:

- **mibluecrosscomplete.com** > Member Benefits> **Transportation Services**
- In the transportation flyer (PDF): *We can help you get there*

Note: Dual-eligible members who have transportation benefits through both BCN Advantage and Blue Cross Complete should exhaust their BCN Advantage benefit before arranging transportation under their Blue Cross Complete benefit.

Specialty care services do not require authorization

Blue Cross Complete members may access specialty care services without an authorization from providers affiliated with Blue Cross Complete. Services rendered by providers not affiliated with Blue Cross Complete, including those outside the state of Michigan, must be preauthorized by calling 1-888-312-5713 (press 1).

Specialty network access

The Michigan Department of Health and Human Services, the Michigan Medicaid health plans and several public entities have worked on a joint initiative to increase access to specialty care services to Michigan Medicaid recipients. Blue Cross Complete does offer a comprehensive provider network, but should a provider determine an in-network specialist is unavailable, the provider can request a referral to access a specialty care provider affiliated with one of the public entities Blue Cross Complete does not contract with (Central Michigan University and Western Michigan University). The following table shows the hospital systems that would require authorization before a member is seen there.

Public entity	Hospital system
Central Michigan University Western Michigan University	• Covenant HealthCare • MyMichigan Medical Center Saginaw

To request assistance with obtaining an authorization, providers can contact Blue Cross Complete's Utilization Management department at 1-888-312-5713 (press 1). Some services are available through unique providers.

Blue Cross Complete also covers services provided by unique providers, such as for services from Federally Qualified Health Centers, Rural Health Clinics, local health departments, family planning clinics and child-adolescent health center services (immunizations, etc.). Guidelines for out-of-state providers

Emergency services rendered by out-of-state providers are covered.

Other services rendered by out-of-state providers must follow the Blue Cross Complete provider authorization process to determine if the service requires a prior authorization. If you are a provider or facility outside of the State of Michigan and are not participating with Blue Cross Complete, please submit all claims through your local Blue Cross Plan (for Blue Card access).

Primary care physicians coordinate care

A primary care physician is a medical doctor or a doctor of osteopathic medicine licensed in the state of Michigan or a nurse practitioner or physician assistant whose practice is primarily in family practice, general practice, internal medicine, internal medicine/pediatrics or pediatrics.

The primary care physician provides and coordinates medical care and services for members.

Members must select a participating primary care physician as soon as they join Blue Cross Complete. Members can use the online provider search to find a physician. These resources provide information on primary care physicians, specialists and other providers across the state.

Every primary care physician listed in the online search must meet Blue Cross Complete's affiliation and credentialing requirements.

B. Role/responsibilities of practitioners

Primary care physician's central role

Each Blue Cross Complete-affiliated provider is valued for the key contributions he or she makes in providing members with the highest quality care in the most effective manner. The primary care physician, in particular, plays a central role.

Each Blue Cross Complete member must select a primary care physician, but members of the same family do not have to have the same physician.

Primary care physician provides access to care

The responsibilities of the primary care physician in providing access to care include but are not limited to:

- Providing telephone access 24 hours a day, seven days a week with a triage mechanism directing members to an appropriately trained health professional
- Accepting a minimum number of Blue Cross Complete members and giving 60 days' written notice of a change in acceptance status
- Being available for patient care a minimum of 20 hours per week at each practice location

Primary care physician provides care

The primary care physician is responsible for providing primary care services to members within the scope of the physician's medical specialty, including:

- Office visits for sick and well care
- Health maintenance exams
- Preventive care services
- Health education
- Inpatient consultations

Primary care physician arranges for care from other providers

The primary care physician's office is also responsible for coordinating care that must be rendered through other providers, including specialty and ancillary services in or out of the hospital, as medically indicated. Examples include:

- Specialty treatment
- Hospitalization
- Post-hospital care
- Ancillary and specialty services using Blue Cross Complete-contracted vendors
- Referrals to chronic condition and care management programs
- Prescription medications, following the Blue Cross Complete custom formulary, as appropriate
- Referrals to health education programs
- Providing or referring for habilitative care (only for Healthy Michigan Plan members)
- Referring for hearing aids

Pediatric and obstetrician-gynecologist services are accessed by Blue Cross Complete members without a referral from their primary care physician.

Guidelines related to practitioners covering for primary care physicians

The primary care physician must provide for member care at all times and ensure that covering or on-call medical personnel are of like or similar specialty and are Blue Cross Complete-affiliated providers who understand the procedures for managing Blue Cross Complete members.

Specialists have responsibilities

It is the responsibility of the specialist to:

- Provide services in a manner commensurate with the standards of practice for the physician's specialty
- Provide a timely written report to the member's primary care physician for inclusion in the member's medical record
- Use Blue Cross Complete-contracted agencies and facilities for tests or services provided to members, except as authorized by Blue Cross Complete
- Allow primary care physicians access to the Blue Cross Complete member's medical record upon request

Specialists expected to share information with primary care physician

As part of Blue Cross Complete's continuing commitment to ensure that members receive the highest quality and safest care possible, specialists, including OB/GYNs and behavioral health practitioners, are expected to share members' clinical information with members' primary care physicians.

Blue Cross Complete medical record standards and National Committee for Quality Assurance standards require evidence of continuity and coordination of care. In addition, provider contracts specify that the specialist's timely communication with the referring physician is essential to effectively manage the member's care. This requires providing information to the member's PCP about the episodes of care rendered in different settings. Documentation should be sent to and received by the primary care physician within 30 days of service.

Note: Behavioral health specialists are permitted by law to share behavioral health information without signed written consent from the member. A signed written consent from the member is required by law before the release of information related to the treatment of substance abuse or HIV.

Guidelines related to practitioners covering for specialists

It is the responsibility of the specialist to provide for member care at all times and ensure that covering or on-call medical personnel are of like or similar specialty and are Blue Cross Complete-affiliated providers who understand the procedures for managing Blue Cross Complete members.

C. General responsibilities of all contracted providers

General responsibilities of all providers who contract with Blue Cross Complete

Providers who affiliate with Blue Cross Complete sign an applicable provider agreement that outlines their responsibilities. The following is a summary of what Blue Cross Complete expects from contracted providers:

Note: This summary applies to all providers, including primary care physicians, specialists and hospital and ancillary providers.

- Providers will cooperate with all Blue Cross Complete programs as outlined in the *Blue Cross Complete Provider Manual* and Blue Cross Complete policies.
- Providers will comply with applicable authorization procedures set forth by Blue Cross Complete for the validation and payment of covered services. Providers are responsible for verifying the current and proper authorization of all nonemergency services prior to providing such services. Providers will seek appropriate authorization for any proposed additional services or for services for which the initial authorization period has expired at the time of service.
- Physicians will utilize Blue Cross Complete's network of contracted providers unless services cannot be provided by the in-network providers.
- Providers will maintain adequate medical and general liability coverage as prescribed in each provider's Blue Cross Complete affiliation agreement and all licenses, certifications, accreditations and practice privileges required by law. Providers will furnish proof of such credentials upon Blue Cross Complete request. Providers will fully comply with applicable Blue Cross Complete credentialing requirements and will immediately notify Blue Cross Complete of any material changes in the provider's licensure, certification, accreditation or practice privileges. Providers will furnish covered services in accordance with each provider's legal qualifications and professional capabilities in a manner consistent with professionally recognized standards of health care.
- Providers must provide all identifying information (phone numbers, group affiliations, National Provider Identifier, tax identification number, billing address, etc.). When that information changes, providers must update the information at least 60 days in advance of the change, when possible. This also applies to information about changes in physician staffing; after-hours and vacation coverage; and practice locations. This also applies to other types of changes.

Note: Changes should be submitted using the Blue Cross Complete **Provider Change Form**, located at **mibluecrosscomplete.com**, under the "Change and Enrollment Forms" heading. Submit the form according to the instructions outlined on the form. Providers may call Blue Cross Complete Provider Inquiry at 1-888-312-5713 with any questions.

- Providers will treat Blue Cross Complete members in the same manner and with the same quality and promptness as other patients are treated. In providing covered services, providers will refrain from discriminating against any Blue Cross Complete member on the basis of his or her Blue Cross Complete membership, source of payment, sex, ethnicity, age, race, color, religion, national origin, ancestry, rital status, sexual preference or any factor related to health status, including but not limited to medical condition (including conditions arising out of domestic violence), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or handicap, or any other basis prohibited by federal law.
- Providers will look solely to Blue Cross Complete for payment of covered services and will accept Blue Cross Complete payment as payment in full for all covered services. The only exception is that providers will pursue payments from other responsible payers when appropriate.
- Providers will, to the extent possible, comply with federal standards designed to promote the use of health information technology.
- Providers will allow Blue Cross Complete to use provider performance data for quality improvement activities.
- Providers will submit claims for covered services in accordance with Blue Cross Complete-specified formats and using Blue Cross Complete-designated claim forms and the provider's NPI.
- Providers will comply with all applicable state and federal legislative, regulatory and legal requirements.
- Other than the appropriate discharge of a patient, providers are expected to refrain from withholding care, appointment access, medication, prescriptions or treatment of any kind or for any reason.
- Providers will comply with and adhere to the American Medical Association Principles of Medical Ethics (Code of Medical Ethics and Conduct) in the care and treatment of Blue Cross Complete patients.
- Neither Blue Cross Complete nor its providers shall use any financial incentive or accept any reimbursement that either directly or indirectly is an inducement to deny, reduce, limit or delay specific medically necessary and appropriate services.
- Providers will comply with all obligations outlined in their provider contracts and in the amendments to those contracts.

Facilities, Equipment and Personnel

The provider's facilities, equipment, personnel and administrative services must be at a level and quality standard necessary to perform duties and responsibilities to meet all applicable legal requirements, including accessibility requirements of the Americans with Disabilities Act.

Medical Records

Providers will maintain accurate and timely medical records for Blue Cross Complete members for at least ten years in accordance with all federal and state laws, ensure the confidentiality of those records and afford access to those records by authorized Blue Cross Complete representatives, peer reviewers and government representatives within 30 business days of the request at no charge. The medical record must include, at a minimum:

a) A record of outpatient and emergency care

b) Specialist referrals

c) Ancillary care

d) Diagnostic test findings including all laboratory and radiology

e) Therapeutic services

f) Prescriptions for medications

g) Inpatient discharge summaries

h) Histories and physicals

i) Allergies and adverse reactions

j) Problem list

k) Immunization records

l) Documentation of clinical findings and evaluations for each visit

m) Preventive services/risk screening

n) And other documentation sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided

Medical records must be signed, dated and maintained in a detailed, comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an organized system for coordinated care and follow-up treatment.

Providers must store medical records securely and maintain written policies and procedures to:

- Maintain the confidentiality of all medical records
- Allow access to authorized personnel only
- Train staff periodically on proper maintenance of member information confidentiality
- Maintain medical records so that records are documented accurately and in a timely manner, are readily accessible and permit prompt and systematic retrieval of information

Blue Cross Complete provides training and evaluates provider's compliance with the recognized medical records standards.

Provider Directory Accuracy forms

Each quarter Blue Cross Complete conducts a sample survey of the online provider directory. Selected providers will receive a Provider Directory Accuracy form to verify that the information we have in our system is correct for their practice.

Follow the steps to complete the PDA form:

1. Review the form in its entirety
2. If no changes are found, initial in the "*All Information is accurate*" box
3. If changes are found, note the changes under each section on the form
4. Email, fax or mail the change form, along with supporting documentation, to:

   Blue Cross Complete of Michigan
   Attn: Provider Data Management
   Suite 1300
   4000 Town Center
   Southfield MI 48075

Fax: 1-855-306-9762

BCCProviderData@mibluecrosscomplete.com

(Please indicate "**Provider Directory Accuracy**" in the subject line to ensure timely processing)

Physicians expected to comply with AMA Code of Medical Ethics

Blue Cross Complete expects physicians to comply with the American Medical Association Code of Medical Ethics, which encourages physicians to select a personal physician for their regular health care and refrain from treating themselves or their immediate family members.

In addition, physicians shall not bill Blue Cross Complete for covered services provided to themselves or to their immediate family members.

The following Blue Cross Complete Quality Management policies and procedures also apply:

- Practitioners found to have selected themselves as their own primary care physician or as the primary care physician for their immediate family members are notified that they are not eligible to do so and are asked to select another appropriately qualified practitioner. If the practitioner fails to select another appropriately qualified practitioner, Blue Cross Complete will make the reassignment.
- Practitioners who have provided billable medical services to themselves or to their immediate family members will be notified that they are not eligible to do so and will be asked to select another appropriately qualified practitioner for medical services.
- Practitioners who have provided billable medical services for themselves or for their immediate family members will be contacted by Blue Cross Complete's regional chief medical officer or his or her designee.

  These activities are tracked in accordance with Blue Cross Complete's Quality Management policies and procedures.

D. Responsibilities of hospital/ancillary providers

Responsibilities of hospital and ancillary providers

It is the responsibility of hospital and ancillary providers to:

- Accept Blue Cross Complete members and, except in emergencies, provide only authorized services
- Coordinate with the member's primary care physician or with Blue Cross Complete, if necessary, in the following situations:
  - When additional treatment or tests are needed
  - When the treatment will exceed the dates on the initial authorization
- Use Blue Cross Complete-affiliated providers and facilities for tests or services provided to members unless services cannot be provided by in-network providers

E. Provider termination

Blue Cross Complete notifies members when a provider terminates

When a primary care physician is terminated or ends its affiliation with Blue Cross Complete for any reason, Blue Cross Complete will provide timely written notice of the physician's termination to all of the physician's members within 30 days of the date of notification.

If the terminating provider is a primary care physician, all members assigned to that physician will receive written notification.

If the terminating provider is a specialty care provider, members with a recent claim with that provider will receive written notification.

Providers wishing to terminate must notify Blue Cross Complete

Providers are required under their affiliation agreements to provide written notification 60 days in advance to Blue Cross Complete when they wish to terminate their Blue Cross Complete provider affiliation. Providers must terminate their Blue Cross Complete affiliation in accordance with the terms and conditions of their provider agreement and continue to provide covered services to members. Providers should refer to their contract for the proper notification time period and any additional requirements for termination. Timely notification of provider termination assures proper payment to providers and assures continuity of care for Blue Cross Complete members.

Providers are reminded that timely notification to the members is facilitated by the notification that providers must give to Blue Cross Complete.

Blue Cross Complete assigns a new primary care physician

Blue Cross Complete notifies members of their primary care physician termination and assigns a new primary care physician. Members can call Blue Cross Complete Customer Service at 1-800-228-8554 between 8 a.m. and 7 p.m. Monday through Friday, to change their primary care physician if they so choose. (TTY users should call 1-888-987-5832.)

Members receive additional information from Blue Cross Complete to assist them in the transition, if the Blue Cross Complete network is modified. Members who are pregnant or have a terminal illness and who want to continue their care with their current provider, even though the provider has terminated his or her Blue Cross Complete affiliation, should contact Blue Cross Complete Customer Service.

Blue Cross Complete notifies members when a specialist terminates

When a specialist or specialty group has requested termination of Blue Cross Complete affiliation, Blue Cross Complete notifies the affected members about the termination and will assist affected members in transferring to the care of another affiliated provider. Blue Cross Complete will inform affected members of the financial consequences of continuing care with the provider after disaffiliation — specifically, that although the provider cannot bill the members, the members also cannot continue to see a nonparticipating provider. Affected members are those members who have been under the ongoing care of the specialist or specialty group.

Note: Members may continue to see disaffiliated providers in certain circumstances.

As part of the process, the Blue Cross Complete care manager also works with the member's primary care physician to arrange for new referrals.

The provider is expected to notify any Blue Cross Complete member who seeks services after the termination that the provider is no longer affiliated with Blue Cross Complete.

Where to submit termination notices

Termination notices should be submitted in accordance with the notice requirements of the provider agreement. Providers should submit termination notices for Blue Cross Complete to:

Director, Provider Network Management
Blue Cross Complete
4000 Town Center
Suite 1300
Southfield, MI 48075

F. Blue Cross Complete's commitment to providers

What providers can expect from Blue Cross Complete

Primary care and specialty physicians and hospital and ancillary providers can expect Blue Cross Complete to:

- Process and pay claims for covered and authorized services in a timely fashion and in accordance with state and federal law
- Provide active quality management, utilization management and care management programs
- Maintain a credentialing program for providers
- Respond to provider inquiries in a timely manner
- Inform providers about changes to Blue Cross Complete's programs, policies and procedures in a timely manner
- Inform providers about how Blue Cross Complete coordinates interventions with treatment plans for individual members
- Inform providers about how to contact the Blue Cross Complete staff responsible for providing care management services to members
- Support providers to make decisions interactively with members regarding their health care
- Treat providers with courtesy and respect
- Inform providers about how to communicate complaints regarding Blue Cross Complete's programs, services and staff
- Carry out other responsibilities as outlined in the provider contracts and in the amendments to those contracts.

Processes for appeals or complaints

Blue Cross Complete has specific appeal processes for providers who disagree with a decision regarding credentialing, quality concerns, pharmacy, care management or claims. These processes are described as follows:

- For information on credentialing processes, visit **bcbsm.com** and log in to Provider Secured Services to access provider manuals. Download the Blue Care Network Provider Manual or one of the Blue Cross Blue Shield of Michigan provider manuals and reference their Affiliation sections.
- For information on addressing quality concerns, see the "Monitoring the Quality of Care" section of this manual.
- For information about appealing decisions on authorization requests related to medications, see the "Pharmacy Services" section of this manual.
- For information on appealing claims denials, see the "Blue Cross Complete Provider Appeals" section of this manual.
- For information about appeals related to the temporary increased payment rate for primary care services, see the "Blue Cross Complete Claims" section of this manual.

Providers who have a general complaint regarding Blue Cross Complete programs, services or staff should contact their Blue Cross Complete provider account executive.

Credentialing – Health care professional and provider rights

Health care professionals and providers have the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information.
- Be notified if any credential information is received that varies substantially from application information submitted by the health care professional or provider: (actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of reference, recommendations or other peer-review protected information. When information is obtained through credentialing that varies substantially from information submitted by the provider, our Credentialing team will notify the provider to correct the discrepancy. The health care professional or provider will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his or her application. The provider will have two weeks from the date of the notification to correct erroneous information. All requests for the above information must be made in writing by the provider. Upon request, be informed of the status of their application – if application is current and complete, the applicant can be informed of the tentative date that his or her application will be presented to the Credentialing Committee for approval. Requests must be made to Blue Cross Blue Shield and Blue Care Network of Michigan Corporate Credentialing, in writing. BCBSM/BCN Corporate Credentialing requires a two-week notice in which to schedule a review date and time. BCBSM/BCN Corporate Credentialing will inform the practitioner in writing of the dates and times available for the review. Upon receipt of the practitioner's response, BCBSM/BCN Corporate Credentialing will confirm in writing the date and time of the scheduled review.

G. Obligations of recipients of federal funds

Providers obliged to comply with requirements

Providers affiliated with Blue Cross Complete 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 and the Americans with Disabilities Act of 1990.

Blue Cross Complete is prohibited from issuing payment to a provider or entity that is debarred from any federal or state agency. To comply with this requirement, Blue Cross Complete will not issue payment to any provider who appears in any of the following lists:

- Social Security Administration's Death Master File
- National Plan and Provider Enumeration System
- List of Excluded Individuals/Entities (LEIE)
- System for Award Management (SAM)
- Medicare Exclusion Database
- MDHHS/Behavioral and Physical Health and Aging Services Administration Sanctioned Provider List
- Licensing and Regulatory Affairs Disciplinary Action Reports

A possible exception to this prohibition is payment for emergency services under certain circumstances.

In addition, providers are prohibited from employing directors, officers, managing partners, agents, employees or persons with beneficial ownership of more than 5 percent who appear on any of these databases. Providers must check the databases when hiring and must also check their staff against the LEIE and SAM no less frequently than monthly.

A code of conduct, as referred to by CMS guidelines, is a set of values and ethical standards that both Blue Cross Complete and providers should adhere to in order to prevent, stop or correct noncompliance.

Providers are expected to adhere to the Blue Cross Complete code of conduct and also to create one for their office that best fits the culture in their office. The code of conduct should be a written document, easily accessible by employees.

Effective lines of communication

CMS emphasizes the importance of open and effective lines of communication as an integral part of a compliance program. Having effective lines of communication means that Blue Cross Complete, providers, and their employees are made aware of the following through training and management:

- What is expected of them regarding ethics and compliance based on the code of conduct
- That compliance is everyone's responsibility
- How to report instances of suspected fraud, waste, abuse and noncompliance

It is important that employees are comfortable with reporting noncompliant activities within their own organizations. CMS emphasizes that effective communication not only means that employees may report noncompliant activities anonymously, but also that employees understand they are legally protected from retaliation when they report suspected noncompliance in good faith.

H. Electronic health records

Use electronic health records

Blue Cross Complete encourages the use of electronic instead of paper medical records for maintaining members' health information. Some advantages of electronic health records are:

- Availability of accurate and complete information anytime the member presents to health care providers to aid in diagnoses and treatment
- Enhanced ability to coordinate a member's care among various health care providers
- Reduced paperwork and increased efficiency for members and providers

Get help making the change to electronic health records

The Michigan Center for Effective IT Adoption is dedicated to assisting providers in making the transition to electronic health records. M-CEITA provides education, outreach and technical assistance for providers in developing digitized patient information, physician order entry and decision support mechanisms.

Providers may contact M-CEITA by telephone at 1-888-MICH-EHR (1-888-642-4347). Providers may access additional information about M-CEITA's services at mceita.org.

EHR incentive programs are available

Information on EHR incentive programs is available at the following locations:
Information on programs offered by the Centers for Medicare & Medicaid Services, including a timeline for incentive payments, is available at **cms.gov** > Regulations & Guidance > Legislation > **Promoting Interoperability Programs**.

- Other information is available at "Electronic Health Record (EHR) Incentive Program" section of the *General Information for Providers* chapter of the MDHHS *Medicaid Provider Manual*.

Section 3: Clinical Practice and Preventive Care Guidelines

A. About the guidelines

Purpose of the guidelines

Blue Cross Complete promotes the development, approval, implementation, monitoring and revision of uniform evidence-based clinical practice and preventive care guidelines for practitioners. Such guidelines promote the delivery of quality care and reduce variability in physician practice. Evidence-based guidelines are nationally known to be effective in improving health care outcomes.

All guidelines are intended as a general resource to assist the practitioner and are not meant as a substitute for the practitioner's medical judgment. They are based on current medical literature, including existing guidelines and practice standards within the community.

Encouraging adherence to the guidelines

Adherence to the clinical practice and preventive care guidelines is encouraged by Blue Cross Complete. This encouragement is provided through interventions focusing on improving health outcomes for Blue Cross Complete members, which include the following:

- Member and provider incentives
- Reminder mailings
- Telephone reminders
- Newsletter articles
- Educational materials
- Case Management/Care Coordination

Ongoing monitoring of compliance with the preventive health guidelines is conducted through medical record reviews and quality studies.

Distribution of practice guidelines

Guidelines and updates are accessible to all providers at **mibluecrosscomplete.com** in the provider section under **Resources**. Blue Cross Complete also distributes clinical practice guidelines to members and prospective members upon request. Blue Cross Complete will mail clinical practice guidelines to those who do not have fax, email or internet access.

Providers are instructed how to access Blue Cross Complete clinical practice guidelines and informed about updates regularly via provider newsletters, **mibluecrosscomplete.com** and in this *Provider Manual*.

To request a copy of the specific criteria used to make a decision on a member's case, call Provider Inquiry at 1-888-312-5713 or your Blue Cross Complete provider account executive.

B. Reporting blood lead tests

Blue Cross Complete providers must report blood lead analysis results

Providers must report to MDHHS the blood lead analysis results of children who are Blue Cross Complete members.

To view the testing plan and get additional information about the MDHHS lead poisoning prevention program, providers can:

- Go to **michigan.gov/leadsafe**
- Call 517-335-8885

Forms related to the collection and submission of blood samples and the reporting of test results are available at **mibluecrosscomplete.com**. They can be located in the MDHHS Forms tab under the provider section.

C. Other applicable guidelines

Blue Cross Complete guidelines

Blue Cross Complete maintains the following internal guideline at **mibluecrosscomplete.com**:

Note: Blue Cross Complete guidelines supersede any other applicable guidelines.

InterQual® criteria

Blue Cross Complete uses Optum/Change Healthcare's InterQual* criteria to make utilization management determinations regarding balloon ostial dilation (balloon sinuplasty) and bariatric surgery. To request a copy of the specific InterQual criteria used to make a decision on a member's case, call the Utilization Management department at 1-888-312-5713.

*InterQual® is a registered trademark of Optum/Change Healthcare LLC and/or one of its subsidiaries.

Section 4: Managing the Quality of Care

A. Monitoring the quality of care

Providers should identify quality concerns

Blue Cross Complete encourages all areas of the corporation as well as external sources to identify concerns regarding quality of care or service. These quality issues are reviewed and investigated.

Member satisfaction is the goal

The Blue Cross Complete Quality Management department reviews all member reports of quality of care issues. Quality Management staff tracks and trends quality of care concerns. All potential quality of care concerns are submitted to the designated Blue Cross Complete medical officer for review.

Blue Cross Complete conducts member satisfaction surveys that include an assessment of the member's perception of the quality of health care provided.

Providers notify Blue Cross Complete about quality concerns

Blue Cross Complete encourages all providers to actively participate in its continuous quality improvement process. Providers are invited to write to Blue Cross Complete about quality of care concerns. Providers should send letters to:

Blue Cross Complete
Quality Management
P.O. Box 7355
London, KY 40742

For additional information, providers can call Blue Cross Complete Provider Inquiry at 1-888-312-5713.

B. Peer review process

Description of peer review process

Blue Cross Complete uses a formal peer review process to evaluate a practitioner's performance for identified quality of care concerns. The policy applies to all affiliated Blue Cross Complete practitioners and independent licensed practitioners.

The peer review process is used to identify, investigate, analyze, monitor and resolve all potential quality of care issues. The involved physician is notified when an issue is identified.

Activities are confidential

All peer review activities are confidential, in compliance with legal requirements and state statutory standards. The dissemination of practitioner-specific information is limited to the involved practitioner or to those individuals who require the data in order to perform any recommended corrective action.

Examples of quality issues

The following are examples of quality of care issues:

- Deviations from standards and guidelines that can be measured but have no direct impact on the practitioner/patient relationship

- Deviations from medical practice or from generally accepted community medical standards that have the potential to adversely affect the member
- Substandard care that results in or has the potential to result in a significant adverse effect on the member

Steps in the peer review process

The peer review process follows these steps:

Step	Action
1	If the medical director determines that there is evidence of a potential quality of care issue, he or she assigns a severity category and forwards the case to the Quality Management staff for action. The medical director further determines if a provider educational opportunity or corrective action plan is required.
2	The practitioner is notified in writing of the potential quality of care issue, the pending peer review and the right to comment or submit additional documentation for review.
3	The practitioner is advised of any recommended corrective action or quality improvement plan in writing. The practitioner may request a personal conference with the designated Blue Cross Complete chief medical director to discuss the plan, which may include: • Medical record review to determine whether the identified quality issue is an isolated incident or is representative of the practitioner's practice patterns • Prescribed educational activities • Restriction of new member assignment • Termination of affiliation
4	The Quality Management staff monitors and reports the results of the practitioner's corrective action or quality improvement plan to the medical director and the Quality supervisor. A quarterly quality of care activity summary report which details the number of cases, levels assigned to those cases and the final outcome of these cases is presented at the Quality Assessment and Performance Improvement Committee.
5	If the medical director determines the expectations of the plan are met, the corrective action process is closed and the practitioner is notified in writing of this action.
6	If the practitioner does not respond to a corrective action plan request, the case is closed as "failure to comply" and the practitioner's lack of response will be tracked and trended.
7	If the medical director determines that further action beyond assigning a severity category is warranted, he or she may refer the case to the Credentialing Committee for further review. In the event the committee schedules a meeting to review the case, the practitioner would be advised of the process and their rights.
8	If the medical director determines the expectations of the plan are not met, he or she reviews the case in its entirety and determines if additional corrective measures, further disciplinary action or contract termination or affiliation are appropriate. All terminations for quality reasons are coordinated between the medical director and the Credentialing Committee.

C. Disciplinary action or termination

Physician discipline or termination process

When quality of care issues are severe enough to warrant contract termination rather than corrective action, Blue Cross Complete uses an established procedure to initiate disciplinary action or termination of an affiliated practitioner or independent licensed practitioner. The cause of such action may include but is not limited to:

- Quality of care concerns
- Lack of cooperation
- Unsatisfactory utilization management
- Behavior inconsistent with Blue Cross Complete managed care objectives
- Failure to comply with recredentialing standards
- Evidence of fraud
- Exclusion or debarment from Medicare or Medicaid participation
- Other appropriate reasons

Steps in physician discipline or termination process

A practitioner may be terminated by Blue Cross Complete for any reason not prohibited by law. Termination may occur by Blue Cross Complete's declining to recredential an affiliated practitioner, not renewing a time-limited contract or notifying the practitioner of termination during the term of the contract.

The formal steps of the process for termination relating to quality issues are:

Step	Action
1	The medical director and the Quality Management staff assess the validity and seriousness of concerns about a practitioner's performance, behavior, conduct or attitude. Their findings are documented.
2	The involved practitioner is notified of the concern and provided an opportunity for the practitioner to respond in writing within 30 calendar days of the date of the letter.
3	After reviewing all documentation, the designated Blue Cross Complete chief medical officer makes one of the following decisions: • No discipline is warranted • Performance improvement plan required • Committee review recommended • Termination If the case is forwarded to a committee, the committee reviews the case and requests that a corrective action/performance improvement plan is developed. The plan specifies exceptions for change including time frames, whether the practitioner is allowed to accept new patients or referrals, consequences of noncompliance, and plan for follow-up monitoring and feedback.
4	The designated Blue Cross Complete chief medical officer sends a certified letter to the practitioner with a copy of the improvement plan or decision. The letter also notifies the practitioner that he/she has the right to request a personal conference with the appropriate plan medical director. If the corrective action/performance improvement plan is related to the quality of patient care provided by the practitioner and the plan reduces or restricts the practitioner's clinical practice for more than 15 days, the appropriate plan medical director follows the practitioner appeal process
5	Compliance with the corrective action/performance improvement plan is monitored by Blue Cross Complete staff and reported to the appropriate plan medical director. Noncompliance or unsatisfactory compliance with the plan or other terms of discipline may result in termination initiated by Blue Cross Complete or the practitioner group. Termination is pursued in accordance with the practitioner's contract, where applicable.

Expedited procedure

When Blue Cross Complete identifies a concern about a practitioner that may jeopardize member health or safety, the appropriate plan medical director intercedes promptly to assure that appropriate care is arranged for members.

If deemed appropriate, the disciplinary steps may be completed on an expedited basis or the appropriate plan medical director, after consultation with the senior vice president and chief medical office may initiate termination of contractual agreement at any point in the proceedings

Medical boards and data bank must be notified

When, based on quality of care issues, Blue Cross Complete terminates affiliation, rejects an application for affiliation or takes action resulting in restriction or regulation of clinical practice for a period greater than 30 days, Blue Cross Complete is obligated to make an appropriate report to the National Practitioner Data Bank. The credentialing department has responsibility for reporting quality of care concerns to the National Practitioner Databank. Action resulting in restriction or regulation of clinical practice for a period greater than 15 days obligates Blue Cross Complete to make an appropriate report to the State Licensing Board.

Additional information about termination:

The practitioner is informed in writing via certified mail of the plan's decision to terminate and the reason(s) for it.

An effective and consistent appeal process for use by practitioners is followed based on certain administrative issues and quality of care issues.

D. Appealing physician discipline or termination

Physicians can appeal Blue Cross Complete actions

Blue Cross Complete offers an appeal process for practitioners in response to disciplinary action taken or recommended by Blue Cross Complete regarding the quality of their patient care.

An effective and consistent practitioner appeal process is available for when a relevant corporate committee or a plan medical director recommends discipline or termination based on certain administrative issues and quality of care issues.

The appeal process is available for:

- **Administrative issues:** Refers to issues that are determined by Blue Cross Complete to warrant denial of an application for affiliation or continued affiliation and that may be based on legal and nondiscriminatory business or contract issues or requirements; or upon regulatory issues or requirements and aren't quality of care related.
- **Quality of care issues:** Refers to actions or inactions of a practitioner determined by Blue Cross Complete to warrant review under the Blue Cross Complete peer review process, and which are based on a practitioner's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a Blue Cross Complete member. Quality of care issues subject to appeal are those that result in rejection of an application for participation, termination of a contract with Blue Cross Complete or restriction or regulation of clinical practice.

The appeal process is a two-level process.

Level 1 appeal process

The following are the steps for Level 1:

Step	Action
1	The practitioner has 30 days following receipt of the written disciplinary notice restricting the practice or terminating the contract to file an appeal. The practitioner sends the appeal to the following address: Blue Cross Complete P.O. Box 5043 Southfield, MI 48076-5043 ATTN: Corporate Manager, Quality Management Mail Code C330 Practitioners who fail to request an appeal in writing within 30 calendar days following receipt of the notice waive any right to Blue Cross Complete's appeal process.
2	Blue Cross Complete's Clinical Quality Committee reviews the appeal within 30 days of receiving the request. The practitioner or independent licensed practitioner (appealing practitioner) will be advised of the committee's meeting date and his or her right to appear in person at the appeal hearing: • Administrative issues that are determined to fall into the nonemergent appealable category are forwarded to the Credentialing Committee for a first level appeal. The Committee makes a determination and notifies the practitioner within seven days by certified letter. • Administrative issues which result in a practitioner termination and fall into the administrative emergent category and are reviewed by the Emergent Administrative and Quality Appeal Panel which makes a decision on action to be taken. Notification to the practitioner is sent by certified mail within seven calendar days of the decision. • Quality of care issues that are determined to fall into nonemergent category may be appealed and are reviewed by the Quality Appeals Committee within 30 calendar days of receipt of the practitioner's letter requesting a hearing. The Quality Appeals Committee decision is communicated to the practitioner in writing and sent by certified mail within 60 calendar days of the decision. Quality issues that are determined to fall into the emergent category may be appealed and are reviewed by the Emergent Administrative and Quality Appeals Panel. The panel reviews the case and makes a decision on action to be taken. Notification to the practitioner is sent by certified letter within seven calendar days of the decision
3	Within 14 days of receiving the committee's decision, the appealing practitioner may challenge the committee's decision by making a written request for a Level 2 appeal.

Level 2 appeal process

The appealing practitioner may proceed to a Level 2 appeal and request a review of Blue Cross Complete's decision.

The process is outlined as follows:

Step	Action
1	The practitioner sends a request for a Level 2 appeal along with any additional information to the following address: Blue Cross Complete P.O. Box 5043 Southfield, MI 48076-5043 ATTN: Corporate Manager, Quality Management Mail Code C330
2	The appeal is forwarded to Blue Cross Complete's chief medical officer, who reviews and makes the final decision.
3	Within 14 calendar days, Blue Cross Complete's chief medical officer issues a written decision to the practitioner that includes a brief description of the underlying rationale. For non-emergent terminations, a written decision is provided within 30 days. The decision is final.
4	Blue Cross Complete is obligated to notify the appropriate state licensing board of cases that involve quality of care issues that will restrict or regulate a practitioner's clinical practice for more than 15 days. Blue Cross Complete is obligated to make a report to the National Practitioner Data Bank when one of the following actions is taken based on issues related to a practitioner's quality of care: • A practitioner's affiliation is terminated • A practitioner's application for affiliation is rejected • An action is taken that results in the restriction or regulation of clinical practice for a period greater than 30 days

E. Facility onsite reviews

Blue Cross Complete conducts facility onsite reviews

Blue Cross Complete may conduct a facility site review and/or a medical record review for all network practitioners as a result of the following:

- Member complaints
- Deficiencies identified when a site visit is being conducted for another reason, for example, a HEDIS®* review, a quality management study or audit, a disease-specific medical record review, or a medical record review audit
- Member surveys
- Reports from Provider Outreach
- Executive inquiries
- Suspicion of fraud, waste and/or abuse

The Blue Cross Complete quality management coordinator will continue to monitor the facility and/or medical records of the practitioner at least every six months, to detect deficiencies and institute actions for improvement until the performance goals established by Blue Cross Complete are met.

*HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Blue Cross Complete conducts onsite reviews for nonaccredited facilities

Nonaccredited facility providers are reviewed prior to initial credentialing, and every three years afterward. Nonaccredited facilities must meet and maintain acceptable standards of safe and sanitary conditions. The only exception is any facility under a current CMS survey, unless the survey isn't completed within the three year timeframe. In this instance, Blue Cross Complete will conduct a site visit. Medical record review isn't required.

Purpose of facility onsite reviews

The facility onsite review process ensures conformity to Blue Cross Complete criteria for safe and sanitary conditions and complies with requirements established by Michigan's Department of Health and Human Services.

What Blue Cross Complete looks for in a facility review

Blue Cross Complete representatives look for the following certificates as part of the onsite facility review:

- A current Clinical Laboratory Improvement Amendments certificate, if applicable
- Compliance with sterilization procedures, as specified in the Blue Cross Complete facility review criteria
- A current Medical Waste Certificate
- A Radiation Registration (if applicable)
- An X-Ray Over Read statement (if applicable)

Blue Cross Complete requires access to practitioners' offices

Blue Cross Complete quality management representatives and authorized regulatory representatives must have access to practitioners' offices during normal business hours to inspect the facility and to review and copy member medical and mental health records, as required by law and as authorized by the member upon enrollment. These representatives should provide identification upon arrival at the facility.

Section 5: Standards and Ratings

A. Access to appointments

Appointment access standards for medical services

Practitioners should provide appointments to members for medical services according to the guidelines in the following table:

Appointment type	Definition	Standard
PCPs, Pediatrician & OB/GYN		
Preventive care	Complete history and physical, including: • Annual gynecologic examinations • Immunizations • Other preventive care appointments For adults, preventive care should comply with all screenings indicated in the Michigan Quality Improvement Consortium preventive care guidelines as appropriate for the member. Note: View Blue Cross Complete Clinical Practices Guidelines at mibluecrosscomplete.com For children, preventive care should comply with the Early and Periodic Screening, Diagnosis, and Treatment/Well Child Care requirements.	Within 30 business days of member's request
Emergency services (arising suddenly and unexpectedly)	Medical care that directly addresses threats to life, limb, or eyesight that requires immediate judgment such as: • Heart attack • Stroke • Open fractures • Appendicitis Severe allergic reaction that make it difficult to breathe	Immediate, 24 hours per day 7 days a week
Routine primary care (symptomatic, non-urgent)	Appointments for members • Who were previously seen • With conditions that are not life threatening-but that keep recurring, such as rashes and joint or muscle pain	Within 30 business days of member's request
Urgent medical care (acute, symptomatic)	Appointments for acute conditions that are not life threatening, such as: • Fever over 101 degrees Fahrenheit over 24 hours • Persistent vomiting • Mild, persistent diarrhea • New-onset skin rashes	Within 48 hours of member's request
Non-urgent symptomatic care	Symptomatic Care: Non-acute symptoms that are not life- or limb-threatening and not interfering with function. Symptoms are of milder nature or longer duration (e.g., intermittent headaches, fatigue, colds, minor injuries, or joint/muscle pain).	Within 7 days of member's request

Specialty Care		
Specialty care	Includes diagnostic testing, specialized treatment and ongoing management of chronic conditions.	Within 6 weeks of request
Acute specialty care	Short term intensive treatment for illnesses and injuries that require immediate medical attention.	Within 5 business days of request
Prenatal Care		
First or second trimester	Personal medical history, ob/gyn history (prior pregnancies and births), family medical history that may affect pregnancy. Routine lab test. Fetal growth measurement.	Within 7 business days of enrollee being identified as pregnant
Third trimester	Routine prenatal visit to check weight, blook pressure, urine, fetal growth, position of the baby and fetal heart rate.	Within 3 business days of enrollee being identified as pregnant
High risk	Increased health risk for pregnant person, fetus or both.	Within 3 business days.

*Appointment should be with Obstetrician, PCP, certified midwife or other advanced practice registered nurse with experience, training and demonstrated competence in prenatal care.

Behavioral health appointment access standards

Mental health practitioners should provide appointments to members according to the following guidelines:

Mental Health		
Routine mental health care	Cases in which no acute danger is detected and the member's condition is not likely to worsen significantly	Within 10 business days of member's request
Urgent mental health care	Conditions that are not life threatening, but for which face-to-face evaluation is necessary within a short period of time (for example, acutely worsening symptoms accompanied by significant environmental change such as discontinuation of attendance at school or work). Examples: • A member calls the provider reporting she was recently discharged from inpatient psychiatric care and is uncertain about how to manage current symptoms and how to transition back to work and home. • A member was recently discharged from inpatient care after a suicide attempt and calls his provider stating he is compliant with medications but is experiencing a decrease in appetite and problems sleeping through the night. He reports he has strong family support and family members are available to stay with him. He reports being fearful of suicidal ideation returning; he denies being actively suicidal.	Within 48 hours of member's request
Emergency mental health care: conditions that are not life threatening	Conditions that require rapid intervention to prevent deterioration of the member's state of mind that, left untreated, could jeopardize the member's safety. Example: • A member in treatment for substance abuse calls Monday morning to report he has relapsed and binged all weekend and can't stop. He states "I can't go on like this." He reports his wife has kicked him out of the house and won't let him see his children and his sponsor is away.	Within 6 hours of member's request
Emergency mental health care: conditions that are life threatening	Conditions that require immediate intervention to prevent death or serious harm to the member or others. Examples: • A member calls the provider reporting he is saying "goodbye" and plans to shoot himself after they hang up. • A member calls his provider stating he plans to kill his supervisor for suspending him from work due to tardiness. Member is under great financial and marital stress and reports he has a gun in his home.	Immediate assessment by a health care provider, either by phone or in person

Dental health appointment access standards

Dental health practitioners should provide appointments to members according to the following guidelines:

Dental		
Appointment type	**Definition**	**Standard**
Emergency dental services	Requires immediate treatment in order to save a tooth, stop ongoing tissue bleeding or alleviate severe pain. A severe infection or abscess in the mouth can be life-threatening.	Immediately 24 hours/day 7 days per week
Urgent care	Includes replacement of tooth/teeth; treatment of cracked or broken tooth/teeth; treats individuals who experience acute dental pain	Within 48 hours of member's request
Routine care	Includes a professional cleaning, exam and possibly X-rays.	Within 21 days of member's request
Preventative services	Include oral evaluations, routine cleaning x-rays and fluoride treatments	Within 6 weeks of member's request
Initial appointment	Evaluation of overall health and oral hygiene, risk of tooth decay, root decay and gum or bone disease. Evaluation of need to tooth restoration or tooth replacement; check bit and jaws for problems.	Within 8 weeks of member's request

Monitoring appointment access

The information about monitoring appointment access found here applies to primary care, obstetrician-gynecologist, specialty and mental health practitioners.

Blue Cross Complete conducts appointment access reviews annually. Reviews are conducted more frequently for practitioners who do not meet access standards.

Blue Cross Complete contacts the practitioner's office to determine access and records the next available appointment for each of the designated appointment types. Physician-specific member complaints related to access are also analyzed.

The expected performance level for each appointment type is 85 percent within the specified time frame.

Blue Cross Complete provides practitioners with a copy of their individual access performance results within four weeks of their assessment. This may include recommendations for actions for improvement, when applicable. Practitioner-specific access monitoring results are considered at recredentialing.

Blue Cross Complete publishes a summary of the results in the newsletters and other publications.

Monitoring timeliness of appointment

Blue Cross Complete will monitor for complaints to ensure providers offer hours of operations that are no less than the hours of operations offered to commercial enrollees or hours of operations are comparable to the Medicaid Fee For Service, if the provider services only Medicaid enrollees.

Compliance with appointment access standards

If Blue Cross Complete determines a practitioner does not meet appointment access standards, the noncompliant practitioner is reassessed for compliance. If continued noncompliance is found, the practitioner must submit a corrective action plan to the Blue Cross Complete Quality Management department within 30 days of notification.

Follow-up monitoring will occur within 90 days.

If…	Then…
The practitioner's corrective action plan is approved	Blue Cross Complete will notify the practitioner.
The corrective action plan is not approved	Blue Cross Complete will request that the practitioner submit an acceptable corrective action plan within 30 days.
A reply is not received within 30 days	Blue Cross Complete will send a second letter to the practitioner to submit an acceptable corrective action plan within 15 days. Blue Cross Complete will forward copies of the letter to the medical care group administrator, the Blue Cross Complete Provider Network Management director and the Corporate Credentialing Department
A reply to the second letter is not received within 15 days	A Blue Cross Complete provider account executive will conduct a visit to the practitioner's office to review non-compliance standards and to obtain an acceptable corrective action plan.

Corrective action for continuous noncompliance

Blue Cross Complete will send a notification of noncompliance to the Provider Organization of their affiliated practitioners who have been noncompliant for two consecutive years. The Provider Organization is required to submit a corrective action on behalf of the practitioner's office within 30 calendar days. Failure to respond within the allotted timeframe will subject the Provider Organization to Blue Cross Complete's Peer Review Committee for review and decision on the recommended disciplinary action, which may include:

- Removal of the entire medical care group from auto assignment for one calendar year
- Removal of the practice group from participating in incentive programs for one calendar year
- Termination from participation with the health plan

B. Waiting room time

Standards for waiting room time

All Blue Cross Complete members should have appropriate and timely access to their practitioners.

The acceptable office waiting room time is no more than 30 minutes from the scheduled time of appointment. Because situations arise in the practice of medicine beyond the practitioner's control, waiting times may extend periodically beyond the 30-minute time frame. In such cases, the member must be advised of any delay and, whenever possible, provided with an estimated time at which the appointment will begin.

If the member is unable to wait until the practitioner is available, an alternate appointment should be offered consistent with Blue Cross Complete's appointment access standards and according to the member's clinical status.

Monitoring waiting room time

Blue Cross Complete monitors primary care physicians, mental health practitioners and other specialists, for compliance with waiting room guidelines.

C. Access to after-hours care

Standards for access to after-hours care

All Blue Cross Complete members should have appropriate and timely access to their practitioners.

Practitioners must provide their patients with access to care 24 hours a day, seven days a week. Practitioner compliance with these standards helps to ensure that Blue Cross Complete members receive timely service.

Achieving compliance with standards for access to after-hours care

After-hours access compliance can be achieved by one of the following methods:

- Answering service
- On-call pager
- Call forwarding to practitioner's home or other location
- Recorded phone message with instructions that direct the member to a practitioner for instruction in after-hours care

Note: Recorded messages instructing members to obtain treatment via the emergency room for conditions that are not life-threatening aren't acceptable.

Monitoring access to after-hours care

On an annual basis, Blue Cross Complete monitors primary care providers and pediatricians for access to after-hours care by calling practitioners' offices after normal business hours and documenting compliance with standards.

The expected performance level for after-hours care is 100 percent within the specified time frame.

Blue Cross Complete publishes a summary of the results in the newsletters and other publications.

Below is a sample of an acceptable after-hours recorded message. This message provides members who call after-hours with appropriate guidance for action steps.

> *"Hello, thank you for calling Dr. Smith's medical facility. The office is currently closed. If you are experiencing a life-threating emergency, please hang up and dial 911. If you have an urgent medical issue that can't wait until the office opens at [insert time your office opens, press '1' to contact the on-call provider."*
>
> *"If your call is a non-urgent matter, please press '2' to leave a message, and a member of our staff will return your call during normal business hours."*

Note: Best practice is to return the member's call within 30 minutes.

Corrective action plan required for noncompliance

If Blue Cross Complete determines a practitioner does not meet standards for access to after-hours care, the following steps are taken:

1. A letter is sent to the noncompliant practitioner, which indicates the practitioner must submit a corrective action plan to the Blue Cross Complete Provider Network Management department within 30 days of receipt of the letter.
2. A Blue Cross Complete provider account executive attempts to contact the practitioner by telephone to assist in expediting submission of the corrective action plan.

The remaining steps are outlined in the following table:

If…	Then…
The practitioner's corrective action plan is approved	The practitioner is notified, and the office will be called approximately 14 days after receipt of the corrective action plan to reassess compliance with the corrective action plan.
The corrective action plan is not approved	Blue Cross Complete will request that the practitioner submit an acceptable corrective action plan within 30 days.
A reply is not received within 30 days	Blue Cross Complete will send a second letter to the practitioner to submit an acceptable corrective action plan within 15 days Blue Cross Complete will forward copies of the letter to the Provider Organization administrator, the Blue Cross Complete Provider Network Management director and the Corporate Credentialing Department.
A reply to the second letter is not received within 15 days	A Blue Cross Complete provider account executive will conduct a visit to the practitioner's office to review non-compliance standards and to obtain an acceptable corrective action plan.

Corrective action for continuous noncompliance

Blue Cross Complete will send a notification of noncompliance to the Provider Organization of their affiliated practitioners who have been noncompliant for two consecutive years. The Provider Organization is required to submit a corrective action on behalf of the practitioner's office within 30 calendar days. Failure to respond within the allotted timeframe will subject the Provider Organization to Blue Cross Complete's Peer Review Committee for review and decision on the recommended disciplinary action, which may include:

- Removal of the entire medical care group from auto assignment for one calendar year
- Removal of the practice group from participating in incentive programs for one calendar year
- Termination from participation with the health plan

D. CAHPS survey

Provider monitoring through the CAHPS survey

CMS monitors health care providers through the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), set of survey tools given to randomly selected members on an annual basis. Blue Cross Complete conducts a CAHPS survey annually to assess member satisfaction with the plan and their experience with our network of health care providers. The analysis of CAHPS measure results are performed to determine annual plan performance, identify areas of opportunities, identify health disparities between subpopulations, and implement interventions designed to improve member satisfaction.

Section 6: Culturally Responsive Health Care

A. Responding to providers' and members' needs

The objective of Blue Cross Complete's Health Equity and Culturally and Linguistically Appropriate Services program, titled HECLAS, is to ensure that health care services are delivered in ways that are appropriate for and responsive to the cultural and linguistic needs of Blue Cross Complete providers, members and communities. The HECLAS program is structured to follow national CLAS standards and guidelines set forth by the Office of Minority Health and the National Committee for Quality Assurance. This objective is accomplished through the following:

- Improving the collection of provider and member demographic data
- Providing education to associates and providers on best practices for cultural competency and responsiveness in healthcare practices and engagement
- Providing access to translation and interpretive services
- Reducing health care disparities and improving health equity to the communities we serve
- Improving health plan services

Terms and definitions

Providers should be aware of the following terms and their definitions:

- **Cultural competence:** the ability of an individual to understand the social, linguistic, moral, intellectual and behavioral characteristics of a community or population and to translate this understanding systematically to enhance the effectiveness of health care delivery to diverse populations.
- **Culturally and Linguistically Appropriate Services (CLAS):** services that improve the quality of services provided to all individuals, which will ultimately help reduce health disparities and achieve health equity.
- **Cultural Humility:** A reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them.
- **Limited English proficiency:** a designation referring to a member who primarily communicates in a language other than English and has a limited ability to communicate in English
- **Low health literacy:** the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions.
- **Low literacy proficiency:** In Public Law 102-73, the National Literacy Act of 1991, Congress defined literacy as an individual's ability to read, write and speak English and compute and solve problems at levels of proficiency necessary to function on the job and in society, to achieve his or her goals and develop his or her knowledge and potential. Individuals lacking these levels of proficiency would be considered to have low literacy proficiency.
- **National CLAS standards:** standards intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations. These standards can be located at: **cms.gov**.
- **Sensory impaired:** a person whose sight, hearing, smell, touch, taste or spatial awareness is impaired .

B. Aspects of culturally responsive care

Translation and interpretation services

Language translation is the process of converting written words from one language into another language in a way that is preferred by the member. Language interpretation is the activity in which oral or sign-language communication (occurring simultaneously or consecutively between users of different languages) is facilitated.

Certified translation and interpretation services are available to all Blue Cross Complete providers and to eligible Blue Cross Complete members whose preferred language may not be English or who have limited English proficiency or low literacy proficiency. Providers are encouraged to use these services to ensure all information is accurately communicated to members.

Members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-8554 for assistance with any or all of the following:

- Interpreting conversations with providers or other health care staff
- Translating health plan documents and medical directives
- Obtaining health plan documents in alternative formats to English and written (example Braille) formats

Translation and interpretive services are available in over 200 languages. Providers and members can call 1-800-228-8554 to:

- Obtain these services immediately over the telephone
- Schedule an appointment for services to be delivered either by telephone or in person

Blue Cross Complete will provide translation and interpretive services after it has been verified that the physician's office does not have their own services for their patients. After verification, Blue Cross Complete will contact member services to complete a *Blue Cross Complete Interpreter Request* form. The request should be complete within 48 hours of services, however, if there is an immediate need for a visit the request can be completed as soon as possible.

TTY and TTD services are also available for both providers and members who are sensory impaired. To obtain these services, providers and members should call 1-888-987-5832.

Education in support of culturally competent and responsive care

Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patient populations are more effective at improving the quality of life of Blue Cross Complete members.

For some Blue Cross Complete members, language is the first barrier to health care. But along with language barriers, culture may influence the following:

- An individual member's health, healing and wellness perspectives
- Systemic barriers and biases a member may experience both inside and outside of a health system or medical home.
- The behaviors of members who are seeking health care and their attitudes toward health care providers

- Experience in the healthcare setting
- Medical adherence and trust in health directives

There are multiple resources available to help providers take the first step in serving diverse populations. Blue Cross Complete offers a Provider CLAS and Equity Training and the Office of Minority Health, part of the U.S. Department of Health & Human Services, offers accredited continuing education programs.

The Blue Cross Complete Provider CLAS and Equity Training is available to all providers and facility staff. This training gives an in depth overview of CLAS, health equity and its importance, how CLAS and equity improves the quality of services, and ways to implement the national CLAS and equity standards in your services.

The Provider CLAS and Health Equity Training is accessible through our website in the provider portal at no cost to participants.

The Department of Health & Human Services offers the following accredited continuing education programs:

- A Physician's Practical Guide to Culturally Competent Care, accredited for physicians, physician assistants and nurse practitioners. Providers may register for this course at **Think Cultural Health**.
- V Competent Nursing Care: A Cornerstone of Caring, accredited for nurses and social workers. Providers may register for this course at **Office of Minority Health**.

Both programs offer continuing education credits and are available online at no cost to participants.

Providers may also visit the **Think Cultural Health home page** and the **Office of Minority Health home page** for more information and for more resources to enhance the cultural competency of their health care practices.

C. Enhancing cultural responsiveness in health care settings

Blue Cross Complete encourages providers and their staff to report their race, ethnicity and the languages they speak. This information can be reported when providers do their attestation through the Council for Affordable Quality Healthcare, or **CAQH**.

The collection of this data is important and encouraged, as it helps to reduce barriers, improve provider/patient relationships and promotes equity. Provider and member information is analyzed to identify opportunities for improvement so Blue Cross Complete can provide the best possible service to its providers and members.

The languages reported by providers are published in the provider directory so members can easily find providers who speak their language.

Additional resources

The following additional resources are available:

- HHS Health Resources and Services Administration: Culture, Language Health Literacy
- National Institutes of Health: Clear Communication / Cultural Competency
- Health Literacy Innovations™
- The Health Literacy & Plain Language Resource Guide

Section 7: Member Eligibility

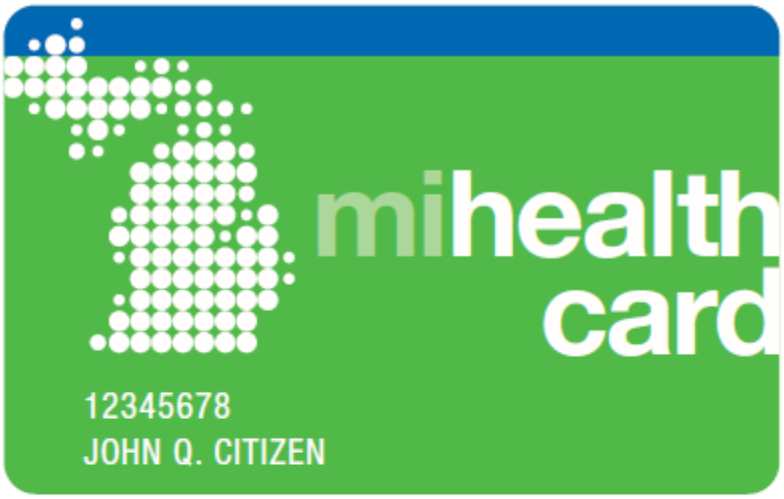
A. Membership ID cards

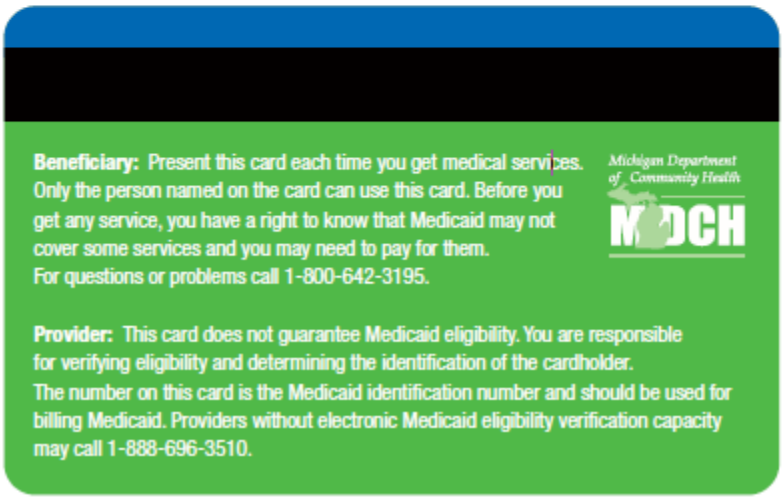
Medicaid ID card

All Blue Cross Complete members are enrolled in either the Healthy Michigan Plan or in another Michigan Medicaid plan. They, along with other Medicaid beneficiaries, receive a state-issued Medicaid ID card, after their eligibility is determined by the Michigan Department of Health and Human Services.

Note: Eligibility for Medicaid is determined by the Michigan Department of Health and Human Services. The administration of the Medicaid managed care programs is carried out by the Michigan Department of Health and Human Services.

The Medicaid ID card is also known as the **mihealth card**. Additional information on the mihealth card is available on the Michigan Department of Health and Human Services website at Michigan.gov.





Medicaid Beneficiary ID number

The Medicaid ID card includes a unique Medicaid Beneficiary ID number for the individual identified on the card. This number identifies the individual as eligible for Medicaid and may be used by providers to verify eligibility with the state of Michigan, via the magnetic stripe that providers can swipe.

Medicaid Beneficiary ID numbers are 10 digits, in line with the Michigan Department of Health and Human Services system known as Bridges.

Blue Cross Complete member ID card

Each Blue Cross Complete member also receives a Blue Cross Complete member ID card. BCC maintains 3 different versions of the ID card. ID card mailing is dependent on the type of Medicaid program the member is enrolled in and the age of the member:

a. Health Michigan Plan members

b. Traditional Medicaid members under age 21

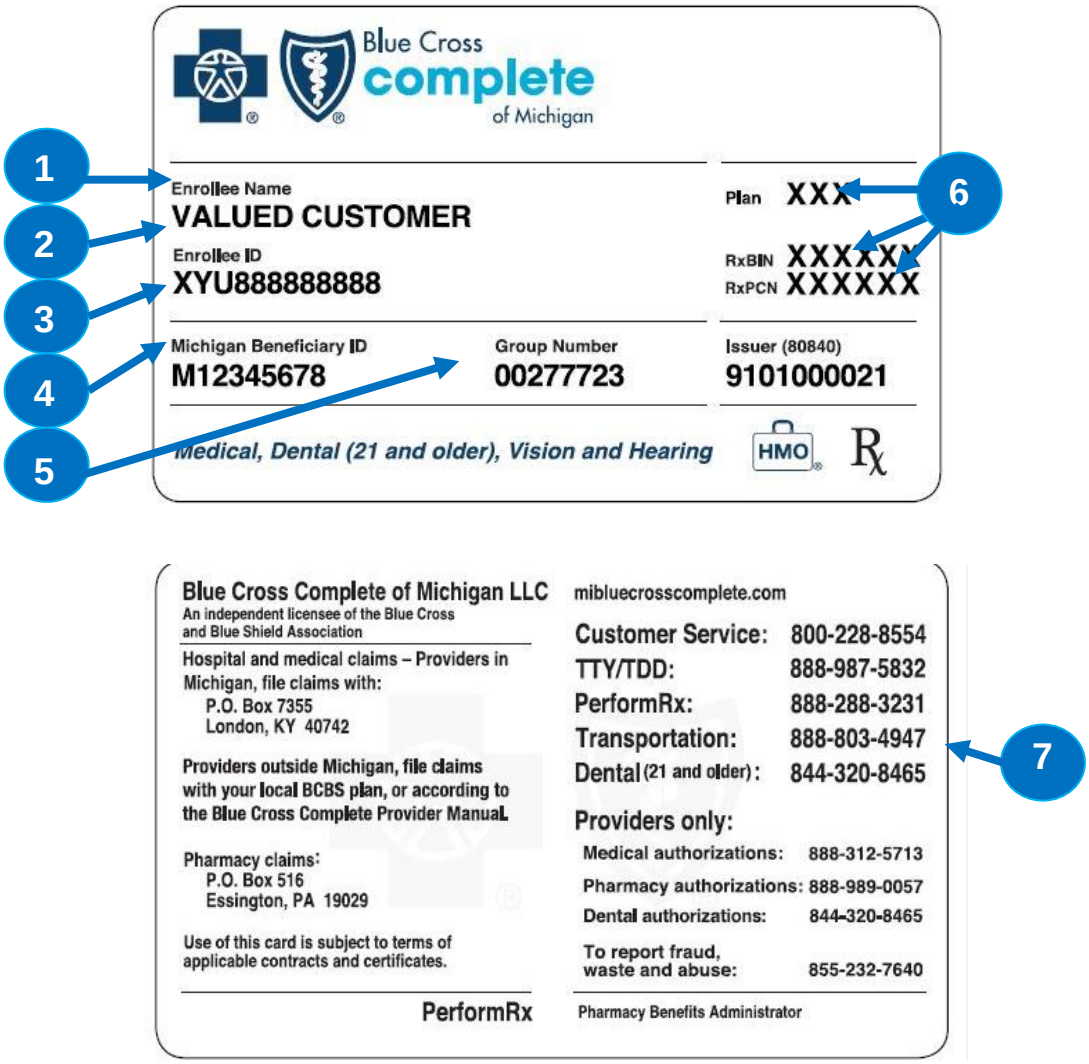
c. Traditional Medicaid members 21 years and older: Member ID cards with dental coverage information are mailed to members transitioning from Healthy Kids Dental via first class mail within 10 Business Days of the first day of the month after the enrollee's 21st birthday

Each Blue Cross Complete member ID card shows:

- **Front Card**:
  - The Beneficiary's name
  - A Facets de-identified contract number
  - The State Medicaid beneficiary ID number
  - The Blue Cross Complete group number
  - Reference to benefits covered by plan:
    - Medicaid members under 21: medical, vision and hearing
    - Medicaid members 21 years and older: medical, dental (21 years and older), vision and hearing
    - Healthy Michigan Plan members: medical, dental, vision and hearing

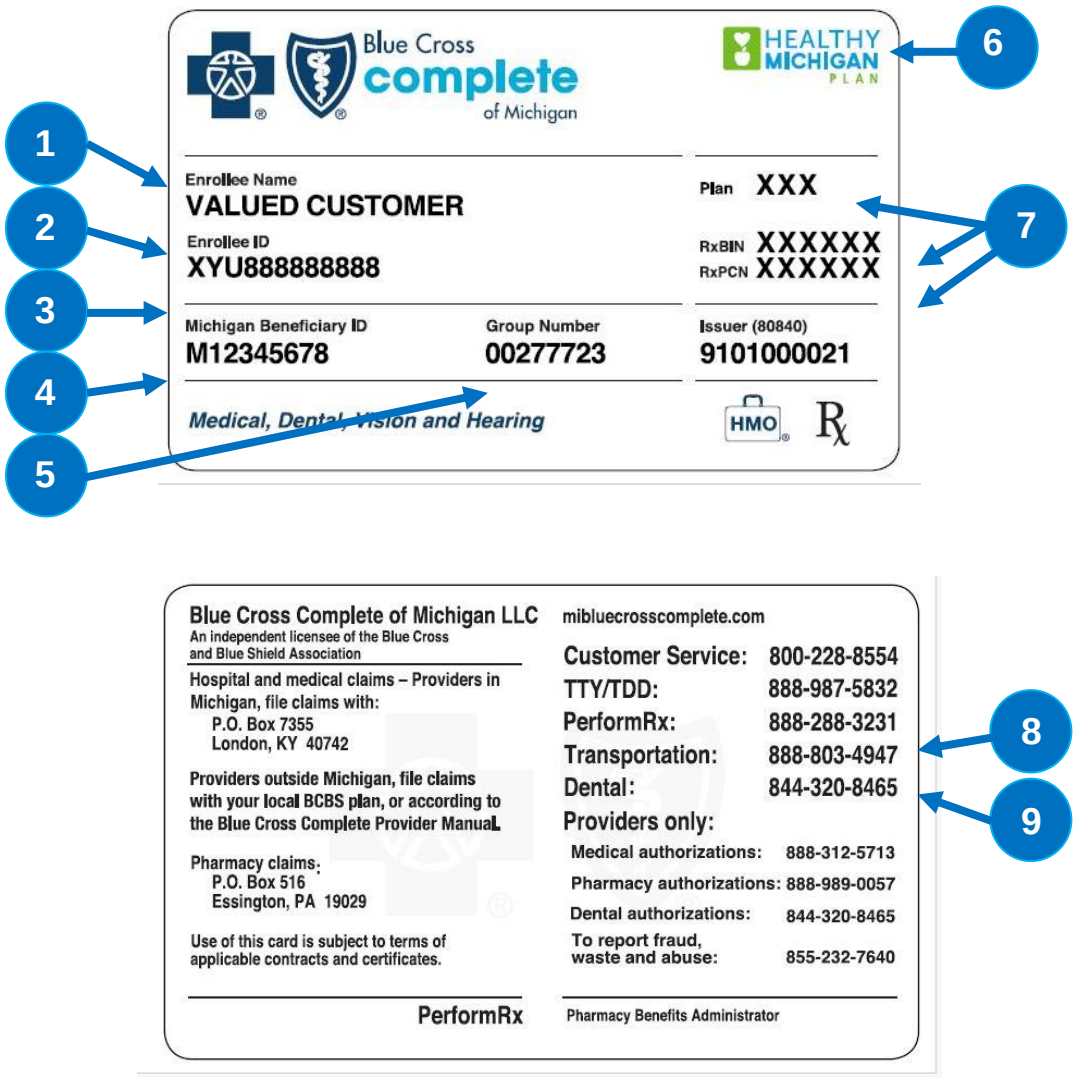
- **Back Card:**
  - Medical claims filing address and authorization phone number
  - Pharmacy claims filing address and authorization phone number
  - Customer service phone number
  - TTY phone number
  - PerformRX customer service number
  - Transportation customer service number
  - Dental customer service number (Medicaid members 21 years and older; Healthy Michigan Plan members)
  - Blue Cross Complete website
  - Fraud, waste and abuse hotline number

Blue Cross Complete member ID card: standard card



No.	Explanation
1	Enrollee Name: Each member gets an ID card in his or her own name.
2	Enrollee ID: Providers should use this number, the member's de-identified Blue Cross Complete contract number, to check eligibility. The Blue Cross Complete contract number begins with the XYU code.
3	Issuer ID number: This number identifies which plan issued the card.
4	Medicaid Beneficiary ID: This is a number issued by the state of Michigan that identifies the member as eligible for Medicaid. Providers may use this number to verify eligibility with the state of Michigan.
5	Group Number: The Blue Cross Complete group number
6	Pharmacy information: Prescription drug coverage under Blue Cross Complete
7	Phone number for transportation services

Blue Cross Complete member ID card: Healthy Michigan Plan card



No.	Explanation
1	Enrollee Name: Each member gets an ID card in his or her own name.
2	Enrollee ID: Providers should use this number, the member's de-identified Blue Cross Complete contract number, to check eligibility. The Blue Cross Complete contract number begins with the XYU code.
3	Issuer ID number: This number identifies which plan issued the card.
4	Medicaid Beneficiary ID: This is a number issued by the state of Michigan that identifies the member as eligible for Medicaid. Providers may use this number to verify eligibility with the state of Michigan.
5	Group Number: The Blue Cross Complete group number
6	The Healthy Michigan Plan logo appears on the front of ID cards issued.
7	Pharmacy information: Prescription drug coverage under Blue Cross Complete
8	Phone number for transportation services.
9	Phone number for dental coverage

B. Checking member eligibility

Always check a member's eligibility

It's essential to check each member's eligibility prior to performing services. Providers should use the standard Blue Cross Complete resources for checking eligibility, including:

- NaviNet, at: **navinet.navimedix.com**
- Availity® provider portal. Providers can request access to Availity at **availity.com/Essentials-Portal-Registration**.
- Blue Cross Complete Provider Inquiry, at 1-888-312-5713 between 8 a.m. and 5 p.m. Monday through Friday
- HIPAA 270/271 electronic standard transaction

Note: For information on the HIPAA 270/271 transaction, providers should email the Availity Client Services team at **availity.com**.

- CHAMPS, the MDHHS Community Health Automated Medicaid Processing System

For Healthy Michigan Plan members, providers must verify that the member is covered by the Healthy Michigan Plan using the member's mihealth (Medicaid) and Blue Cross Complete ID cards. This verification must take place prior to services being rendered. Providers can also verify eligibility for Healthy Michigan via the NaviNet eligibility details screen. On that screen, the Healthy Michigan product name is displayed in the Plan Name field for Healthy Michigan members.

C. Member eligibility data files

Blue Cross Complete members identified in eligibility data files

Through their medical care group or practice administrators, primary care physicians can access monthly electronic member eligibility data files that identify Blue Cross Complete members.

Note: On the monthly panel roster, Healthy Michigan members show HM# after the member's name.

D. Member eligibility, enrollment, disenrollment, effective date

Blue Cross Complete may request member termination for cause

Blue Cross Complete may request special disenrollment (termination for cause) of a member from MDHHS under certain circumstances. When special disenrollment is requested, Blue Cross Complete will notify the member by letter.

MDHHS will review the request; if approved, MDHHS will determine the termination date and will notify Blue Cross Complete. The member has 90 days within which to request a hearing. If a hearing is not requested, MDHHS will provide Blue Cross Complete with an electronic termination record. If a hearing is requested, the member will remain active until a decision is rendered. Once a decision has been made, Blue Cross Complete will receive a notice from MDHHS indicating either that the member will be terminated (with the termination date) or that the member will not be terminated.

Special disenrollment requests may be made in cases of violent, urgent or life-threatening situations involving physical or verbal threats or acts of violence made against Blue Cross Complete providers, staff or the public at Blue Cross Complete locations; or stalking situations.

Special disenrollments will occur only to the extent consistent with the rules and regulations of MDHHS. All rights to benefits cease as of the effective date of the disenrollment. Claims for services provided prior to the effective date of the disenrollment are still eligible for reimbursement.

Retroactive member terminations may occur

Retroactive member terminations may occur, resulting in the recovery of monies paid by Blue Cross Complete when the member was ineligible for coverage through Blue Cross Complete.

Subject to the terms of the Blue Cross Complete provider agreement, Blue Cross Complete may collect any overpayments made to a provider in error, including any payments made for services provided to a member after the retroactive termination. Overpayments on facility claims will be recovered up to six months from the date paid or the end date of the member's eligibility, whichever occurs sooner. This applies to both professional and facility payments. When there is fraud involved, payments can be recovered without a time limit. When the member is no longer considered eligible, the provider may bill the member's new insurance carrier.

Providers who have questions regarding payments that are taken back should contact Blue Cross Complete Provider Inquiry at 1-888-312-5713 between 8 a.m. and 5 p.m., Monday through Friday.

E. Dual-eligible members

What is a dual-eligible member?

A dual-eligible member is one who qualifies for both Medicare and Medicaid. Dual-eligible members are those enrolled in either original Medicare or a Medicare Advantage plan as their primary health insurer and Blue Cross Complete as their secondary.

For dual-eligible members, the Medicare plan — either original Medicare or Medicare Advantage — is always the primary plan. Blue Cross Complete is secondary.

Note: Dual-eligible members are voluntarily enrolled by MDHHS and may opt out of the dual-eligible program later if they choose.

Blue Cross Complete provides secondary coverage

As the secondary plan, Blue Cross Complete covers the copayments, coinsurance and deductible — the member's out-of-pocket expenses — that are not covered by the primary plan. In general, Blue Cross Complete pays the lesser of the member's liability under the primary plan or the amount Blue Cross Complete would have paid as the primary plan less any payments made by the Medicare primary plan. Providers must hold the member harmless for any remaining sums.

Note: This applies to medical services. Blue Cross Complete doesn't pay copayments, coinsurances and deductible for Medicare-covered Part D (pharmacy) services.

Blue Cross Complete assigns the primary care physician

When an individual is enrolled as a dual-eligible member, the Blue Cross Complete secondary plan selects a primary care physician affiliated with Blue Cross Complete and sends the member a notification letter. The primary care physician selected by Blue Cross Complete may or may not be the physician the member is used to seeing under the primary Medicare plan.

Dual-eligible members are not required to see the primary care physician selected by Blue Cross Complete. These members may continue to receive Medicare-covered services from their current physician.

Note: If the physician the member is used to seeing under Medicare is affiliated with Blue Cross Complete, Blue Cross Complete will select that physician as the member's primary care physician of record for Blue Cross Complete. If the physician the member is used to seeing under Medicare is not affiliated with Blue Cross Complete, Blue Cross Complete will select another physician as the member's primary care physician of record for Blue Cross Complete.

The primary plan determines the rules for referrals and authorizations

For referrals and authorization requests related to dual-eligible members, providers should follow the rules of the member's primary plan.

Additional information about dual-eligible members

Additional information about dual-eligible members is available as follows:

- Information about transportation services is available in the "Blue Cross Complete provider network" section of this manual.
- Information on review of readmissions for dual-eligible members is available in the "Review of inpatient admissions and discharge planning" section of this manual.
- Information on medications for dual-eligible members is available in the "Pharmacy Services" section of this manual.
- Information on billing for dual-eligible members is available in the "Blue Cross Complete claims processing" section of this manual.

Providers can also access a document titled ***What you should know when serving dual-eligible members*** at **mibluecrosscomplete.com.**

Section 8: Member Benefits

A. Blue Cross Complete primary care physician services

Process for primary care physician selection or assignment

Each Blue Cross Complete member may select his or her primary care physician from among those affiliated with Blue Cross Complete. Blue Cross Complete members can get assistance with the selection of a primary care physician from Blue Cross Complete Customer Service by calling 1-800-228-8554 between 8:00 a.m. and 7:00 p.m. Monday through Friday. (TTY users should call 1-888-987-5832.)

Adult Blue Cross Complete members may change their primary care physician or that of their minor dependent for any reason by calling Blue Cross Complete Customer Service. Changes in primary care physicians become effective the day of the request.

Note: Foster care parents who want to change the child's primary care physician must contact their MDHHS caseworker.

If a beneficiary doesn't choose a Blue Cross Complete pediatrician to be a child's primary care physician, the child can still be taken to a Blue Cross Complete pediatrician or family practitioner for pediatric services without a referral from the primary care physician.

Blue Cross Complete reserves the right to choose a primary care physician for the member in the event the member doesn't indicate a physician selection.

Sending medical records to a new primary care physician

When a member changes to another primary care physician, regardless of who requested the change, the current primary care physician must provide copies of the member's medical records to the new primary care physician within 10 business days from receipt of written request, at no charge. This is to facilitate continuity of the member's care.

Primary care physicians responsible for managing care

Primary care physicians manage their Blue Cross Complete members' medical care. Responsibilities include the following:

- Being available for patient care a minimum of 20 hours per week at each practice location
- Encouraging members to receive needed preventive care
- Monitoring specialty use and making appropriate referrals for required medical care
- Referring members to care management, as appropriate
- Coordinating inpatient admissions
- Directing patients to Blue Cross Complete network physicians for all care
- Prescribing appropriate medications using the *Blue Cross Complete Preferred Drug List* and monitoring for potential harmful interactions; discussing the member's list of medications with the member
- Using Blue Cross Complete resources to link members to necessary support services
- Regularly accessing and reviewing available reports for important information related to member care

- Educating members on the appropriate use of the emergency room (For access and availability standards, see Section 5A, page 30.)

Note: Healthy Michigan Plan members are required to schedule an appointment with their assigned primary care physician within 60 days of enrollment. Primary care physicians are encouraged to assist in getting the appointment scheduled. Blue Cross Complete can also assist in coordinating appointment scheduling. The primary care physician is required to complete the appointment within 150 days of the member's effective date with the plan.

Providing Early and Periodic Screening, Diagnosis, and Treatment/ Well Child Care services

Primary care physicians must abide by the terms and conditions of their Blue Cross Complete provider affiliation agreement in providing Early and Periodic Screening, Diagnosis, and Treatment/Well Child Care services for their Blue Cross Complete members.

Note: Resources for carrying out responsibilities related to the EPSDT Program are available at the website of the Michigan State University Institute for Health Care Studies as follows:

- Access EPSDT Program information at **ihp.msu.edu** > Quality Improvement > **Early Periodic Screening, Diagnosis and Treatment**.
- Access the EPSDT Clinician Toolkit at **ihp.msu.edu** > Quality Improvement **> EPSDT Clinician Toolkit**.

Primary care physicians must communicate with members

Primary care physicians can communicate effectively with members by:

- Sending introduction letters asking new members to come in for a visit
- Discussing current and ongoing health care needs
- Discussing the care members are receiving from other providers
- Discussing their expectations of members (coordinating care, emergency room use, affiliated specialists, affiliated hospitals, etc.)
- Showing sensitivity to member needs (literacy concerns, cultural needs, social support, etc.)

Blue Cross Complete provides primary care physicians with necessary support

Blue Cross Complete will make available to network providers the needed support materials to serve Blue Cross Complete members. This support includes:

- Care management services
- Complex care management services
- Chronic condition management programs
- Reports

Information on these topics is found in subsequent sections of this manual.

Vaccines for Children Program

Protecting children from diseases that can be prevented by vaccination is a primary goal of Blue Cross Complete and MDHHS. Blue Cross Complete encourages providers to participate in the federally funded

Vaccines for Children Basic Program and Vaccines for Children Expanded Program, which are cooperatively run by local and state public health departments. These programs provide certain vaccines at no charge for children who are enrolled in Medicaid, have no insurance, are American Indian or Alaskan Native or are underinsured.

Providers must be enrolled in the VFC Program in order to receive VFC vaccines. Providers who want to sign up as a VFC Program provider or who want to learn more about the VFC Program can contact the VFC Coordinator at the MDHHS Division of Immunization at 517-335-9646 or visit **michigan.gov/mdhhs** > Pregnant Women, Children & Families > Children & Families > **Immunization Info for Families & Providers**.

For more detailed information on what the VFC Program involves, including a list of the vaccines that are covered, providers may access the MDHHS VFC Provider Manual online at **michigan.gov/mdhhs** > Pregnant Women, Children & Families > Children & Families > Immunization Info for Families & Providers > Health Care Professionals / Providers > **VFC Provider Manual**. Additional information can also be found in the "Immunizations" section of this manual.

Children enrolled in foster care

Children in foster care are define as children placed outside of the child's parental home by and under the supervision of a child placing agency, the court or MDHHS, up to the child's 18th birthday or 19th birthday for youth committed to the Michigan Children's Institute (MCL 400.203) or a youth who participates in the Young Adult Voluntary Foster Care up to their 21st birthday.

All children and youth in foster care younger than 21 years of age are required to receive full medical examination and screening for potential mental health issues by a PCP within the first 30 days of entering foster care. This visit must be completed regardless of whether the child in foster care recently received a mental health maintenance visit prior to entry into the foster care system.

Services for children in foster care:

- **Ages 0 – 20 years**: All age-related Well-Child Exams including EPSDT.
- **Ages 3 years and older**: All age-related Well-Child Exams plus a dental exam within 90 days of entering foster care, unless a dental exam was performed within six months prior to entering foster care.

Primary care provider

Children in foster care must be allowed to reside with their current PCP. This includes PCPs within a reasonable distance of the member's foster care living arrangement.

Foster care parents who want to change the child's primary care physician must contact their MDHHS caseworker.

Identifying children in foster care

Children in foster care can be identified on the Eligibility file(s) uploaded in the EDIFACs mailbox or in the provider portal Navinet.net.

B. Blue Cross Complete benefits

Overview of benefits

Blue Cross Complete members are entitled to receive services covered according to the Medicaid coverage guidelines established by MDHHS.

The member's primary care physician will provide services or, when necessary, will coordinate the member's care with a specialty provider affiliated with Blue Cross Complete.

Authorization may be required

Some services are covered only when the primary care physician or other plan provider has obtained an authorization for care (advance approval) from Blue Cross Complete.

Providers should refer to the Blue Cross Complete Prior Authorization Request Updates and Lookup Tool to learn more about services that require prior authorization.

Benefits are explained in the Blue Cross Complete Member Handbook

The details about Blue Cross Complete benefits are available in the *Blue Cross Complete Member Handbook,* which can be accessed at **mibluecrosscomplete.com** > Benefits > **Blue Cross Complete Member Handbook**.

Members can get discounts

Blue Cross Complete members have access to some discounts, as follows:

- Injury prevention items through BlueSafe℠. By showing their ID card, Blue Cross Complete members can save 20 percent on the following:
  - Safety items, at Michigan Dunham's Sports stores
  - Home medical equipment not covered by Blue Cross Complete, at Michigan Wright & Filippis stores
- **Weight Watchers® memberships.** Blue Cross Complete members who show their ID card can get a discount on the initial membership fee.
- **Blue365® savings program.** Blue Cross Complete members can take advantage of special member discounts on a variety of healthy products and services from Michigan merchants. Learn more about these discounts at **mibluecrosscomplete.com/blue365**.

Members are not responsible for costs except through Healthy Michigan Plan

Blue Cross Complete members have no medical copayments and no pharmacy copayments, no deductible or coinsurance and no annual plan dollar maximums.

Providers are required to give Healthy Michigan Plan members a notice of potential co-payments at the time of service. For information about co-pays, amounts of co-pays and services that have a co-payment, visit michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder1/Folder60/WebCo-PayTable_11-02-06.pdf?rev=39dfeae1839e4434b66f503f84d63e45&hash=0011A97D7B51605563D320E49EB224B9.

Note: For conditions exempted from copayments, the diagnosis must reflect the condition on the claim submitted. For institutional invoices, the condition diagnosis must be included in the claim header. For professional and dental claims, the condition diagnoses must be shown on the claim line.

National Prevention Information Network directory

Health care providers are encouraged to join a collaborative approach in the fight against preventable diseases and to promote public health initiatives by registering their practice with the Centers for Disease and Control and Prevention National Prevention Information Network.*

The NPIN serves as an information and referral platform that connects public health providers and the public with information and resources on HIV/AIDS, viral hepatitis, sexually transmitted diseases and tuberculosis. The directory connects members with sexual health services, including Pre-exposure prophylaxis, commonly known as PrEP, in their area. In order for members to locate and access PrEP and other sexual health services, Blue Cross Complete encourages providers to register for NPIN at npin.cdc.gov/organization/submit.

LGBTQ+ resources for providers

Blue Cross Complete is committed to reducing barriers to care experienced by members of the lesbian, gay, bisexual, transgender, queer, intersex, asexual and all sexual and gender minority people, or LGBTQ+ community. We recognize the importance of fostering inclusive, affirming health care environments and are dedicated to supporting providers in delivering culturally competent care. To aid in this effort, Blue Cross Complete offers training opportunities and educational resources focused on LGBTQ+ health equity and best practices. These tools are designed to help providers enhance their understanding, build trust with patients, and ultimately improve health outcomes across diverse populations. LGBTQ+ cultural competency training is available at **mibluecrosscomplete.com**. Providers are encouraged to maintain updated information in the NPIN, which will allow members to locate and access various sexual health services.

Members can find an LGBTQ+-friendly primary care physician or specialist by visiting Find a Doctor page and choose the "LGBTQ+ friendly" filter. If members need help finding a provider, call Customer Service at 1-800-228-8554, 24 hours a day, seven days a week. TTY users, call 1-888-987-5832.

Behavioral Health and Substance Use Disorder

The Michigan Behavioral Health and Substance Use Disorder Authorization and Payment Responsibility Grid is a guideline to assist Medicaid health plans, PIHPs, Community Mental Health Service Programs and providers in determining the responsible entity for authorization and payment.

Note: Guidelines and all entities should follow Michigan Medicaid policies as described in the Michigan Medicaid Provider Manual.

Additional services covered by Blue Cross Complete

Dental benefits

Blue Cross Complete covers dental benefits, including dental exams, cleanings and extractions for members. Additional dental benefits include:

- Four bitewing X-rays every year
- Full-mouth X-rays once every five years
- One filling per tooth every two years
- Emergency exams, no more than twice a month
- Sealants, once every three years
- Topical fluoride up to age 21, twice per year
- Fluoride varnish up to age 21, twice per year
- Crowns, once every five years on the same tooth

- Root canal therapy
- Retreatment of previous root canal, once per tooth per lifetime
- Periodontal evaluation, once every 12 months*
- Periodontal maintenance, once every six months*
- Complete and partial dentures, once every five years per arch

*Periodontal services, including scaling and root planning requires prior authorization.

Eligibility for dental benefits includes:

- Healthy Michigan members ages 19-20 years, including pregnant women, are eligible for dental care coverage through Blue Cross Complete
- Members ages 21 years and older, including Healthy Michigan plan beneficiaries and pregnant women.

Note: Dental services are provided through a dental network managed through Blue Cross Complete's dental benefit manager. Eligible members can locate a dentist by visiting **mibluecrosscomplete.com** and selecting ***Find a Doctor***, and then ***Find a dentist***. Members may also call Dental Customer Service at

1-844-320-8465 (TTY users should call 711). The business hours for Dental Customer Service are 9 a.m. to 5 p.m., Monday through Friday.

Dental care for members under the age of 21

Healthy Kids Dental will provide dental services for Medicaid members under ages 21 years, including pregnant women. Eligible members are automatically enrolled in Healthy Kids Dental. Once the member turns the age of 21 years, the month after their 21st birthday, the member will obtain dental services through Blue Cross Complete's dental provider network. It is essential that dental providers verify the member's eligibility and enrollment prior to each appointment to ensure payment. Eligibility can be verified using the MDHHS CHAMPS system.

Healthy Kids Dental benefits are provided through Blue Cross Blue Shield of Michigan or Delta Dental Plan of Michigan. Covered benefits include diagnostic, preventative, restorative, endodontic and prosthodontics services.

Maternal Infant Health Program

Pregnant Blue Cross Complete members and infants get their primary maternal/infant health services through the Blue Cross Complete Bright Start program or through a certified MIHP provider. These preventive health services are intended to supplement regular prenatal and infant care and help providers manage the member's health and well-being. MIHP services are billed directly to Blue Cross Complete. Services may extend 60 days after delivery. It is the objective of MDHHS and Blue Cross Complete to enroll all pregnant women in an MIHP. For information on how to access MIHP services, providers should call Blue Cross Complete Provider Inquiry at 1-888-312-5713. In addition:

- MIHP providers must be certified by the Michigan Department of Health and Human Services.
- MIHP services include psychosocial and nutritional assessment; professional services rendered by a multidisciplinary team that includes a social worker, nurse and nutritionist; transportation; childbirth (including midwife and nurse practitioner services, if billed as an obstetrics benefit); parenting education; referral to community services; and coordination with medical care providers.

- Care Management staff will contact eligible pregnant members and direct them to appropriate MIHP providers for service.

Providers should refer to the "Pregnancy resources" section of this manual for information on the Blue Cross Complete Bright Start program.

Tobacco cessation

Blue Cross Complete supports members' efforts for Healthy Living. For tobacco cessation, Blue Cross Complete has a tobacco quit program which covers group and individual counseling or coaching to help members quit.

The tobacco quit program is a free, phone –based support program which helps members make a plan to quit using tobacco and offers support and encouragement to members to assist them with sticking to their plan.

The toll-free tobacco quit phone number is: 1-800 784-8669 from 8:00 a.m. to 1:00 a.m. seven days a week. Drug benefits include over the counter and prescription medicines. See Section 12: Pharmacy Services for additional coverage information.

Many services are supplied outside of the health plan

For information on services supplied directly by the state, including on billing (for services not related to Blue Cross Complete), and for copies of state Medicaid forms, providers can contact the Behavioral and Physical Health and Aging Services Administration Medicaid Information Line at 1-800-292-2550. Services supplied directly by the state include:

- **Women, Infants and Children program (through MDHHS**)
- **Developmental disabilities.** Blue Cross Complete primary care physicians must screen for developmental disabilities as part of the required EPSDT visit(s). If a developmental disability is suspected (whether autism or another developmental disability), the Community Mental Health service provider can provide additional evaluation and treatment.
- **Nursing home services.** Blue Cross Complete pays for short term rehabilitative services at a nursing or rehabilitation facility. Medicaid pays for long term nursing home services. Additional information is available through the Behavioral and Physical Health and Aging Services Administration Medicaid Information Line at 1-800 292 2550.
- **Help with drug and alcohol problems.** Members who believe that they or a family member has a problem with drugs or alcohol should contact their regional prepaid inpatient health plan or local substance abuse coordinating agency listed below:
  - For residents of Washtenaw and Livingston counties: Washtenaw Community Health Organization at 734-544-3050 or 1-800-440-7548.
  - For residents of western Wayne county outside of the city of Detroit: Southeast Michigan Community Alliance, at 1-800-686-6543.
  - For residents of the city of Detroit: Institute for Population Health, Behavioral Health Division, at 1-800-467-2452.
  - For a statewide map of publicly funded substance use disorder treatment and counseling services with contact information by county, visit: **michigan.gov/mdhhs/keep-mi-healthy.**
- **Additional services** not covered by Blue Cross Complete that may be available to members include:

- Services provided by a school district
- Mental health services: inpatient psychiatric services and outpatient psychiatric care for persons with severe and persistent mental illness
- Substance abuse services: screening and assessment, detoxification, intensive outpatient counseling and methadone treatment
- Long-term care in the home, through the home and community-based program services
- Home help services
- Transportation for services not covered by Blue Cross Complete

Additional information on how to access these services is available through Blue Cross Complete Provider Inquiry at 1-888-312-5713 from 8 a.m. to 5 p.m., Monday through Friday.

Use the Medicaid telephone number to get additional information about services

Additional information about services available through Medicaid can be accessed through Medicaid's Helpline at 1-800-642-3195.

Special-needs members can get assistance through Customer Service

Blue Cross Complete members who access care in any setting (ambulatory, outpatient or inpatient) can call Blue Cross Complete Customer Service at 1-800-228-8554 (TTY users should call 1-888-987-5832) for assistance with any or all of the following:

- Language translation services
- Interpreting Blue Cross Complete services or written information
- Obtaining written materials in alternative formats
- Refer to the "Multicultural health care" section of this manual for additional information.

C. Members grievance and appeals

Blue Cross Complete member appeals generally relates to the clinical part of the member's medical coverage. Grievances are complaints about other aspects of the member's care. If a member is dissatisfied with his or her practitioner or with Blue Cross Complete, the member has the right to file a confidential grievance at any time. The practitioners can also assist members or complete a grievance on behalf of the member.

Member grievances can be submitted in writing or by calling Blue Cross Complete using the following information:

- Member Grievances
  Blue Cross Complete
  P.O. Box 41789
  North Charleston, SC 29423

- Blue Cross Complete Customer Service
  1-800-228-8554
  24 hours a day, seven days a week

If a written grievance is submitted, Blue Cross Complete will acknowledge receipt within 2 business days of receiving the grievance. The member will receive a resolution within 30 calendar days. Note: Timeframes may be extended up to 14 calendar days if the member request an extension or if Blue Cross Complete determines that additional information is needed and the delay is in the best interest of the member. A grievance can also be presented in person at the following address:

- Blue Cross Complete
  Suite 1300
  4000 Town Center
  Southfield, MI 48075

Members can arrange for transportation to the Blue Cross Complete office by dialing 1-888-803-4947.

Dental Services

Blue Cross Complete members may file a complaint regarding dental services rendered by using the following contact information:

- **In person or by writing:**
  Dental Customer Service
  Blue Cross Complete
  P.O. Box 2819
  Detroit, MI 48202-3231
  9 a.m. to 5 p.m. Monday through Friday
- **Phone:** 1-844-320-8465
- **Fax:** 313-922-5790
- **TTY:** 711

Appeals

A Blue Cross Complete member has the right to file an appeal if he or she disagrees with Blue Cross Complete's decision on medical treatment, service, equipment or medicine.

Blue Cross Complete will send the member a *Notice of Adverse Benefit Determination*. The member must send a request for an appeal within 60 calendars of receipt of the notification. Blue Cross Complete will sent a written acknowledgement of receipt of the appeal within 2 business days..

If a member files an appeal within 10 calendar days from the date of the *Notice of Adverse Benefit Determination*, he or she can request that the same level of service continues while the appeal is pending. If the member have questions or needs assistance with the appeal process, call Customer Service at 1-800-228-8554. TTY users should call 1-888-987-5832.

A member has the right to have a representative file an appeal on his or her behalf. An *Authorization of Member Representative* form must be completed by the member. State and federal rules require that permission be made after the member receives the denial notice. Permission must be specific to the service in question. A member has a right to request a free copy of the guideline or criteria used to make the benefit decision.

Types of Review – standard and expedited

Standard 30-day review

A Blue Cross Complete member can request a standard 30-day review by writing or calling Blue Cross Complete. If the member needs assistance in writing the letter, he or she can contact Customer Service.

The member can send in paperwork, medical records or additional information that supports the appeal. Blue Cross Complete will acknowledge receipt within 2 business days of receiving the appeal. The member will receive a resolution within 30 calendar days. Note: Timeframes may be extended up to 14 calendar days if the member request an extension or if Blue Cross Complete determines that additional information in needed and the delay is in the best interest of the member. The member will receive a written explanation of the extension within 2 calendar days.

Appeals may be filed using the following:
Write, call or fax:

Member Appeals	**Customer Service**
Blue Cross Complete	1-800-228-8554
P.O. Box 41789	24 hours a day, seven days a week
North Charleston, SC 29423	TTY: 1-888-987-5832
Fax: 1-855-737-9879	

Dental Services – For dental appeals, write, call or fax:

Dental Appeals Coordinator	**Dental Customer Service**
Blue Cross Complete	1-844-320-8465
P.O. Box 2819	9 a.m. to 5 p.m. Monday through Friday
Detroit, MI 48202-3231	TTY: 711
Fax: 1-313-922-5790	

Expedited or urgent review (72 hours):
A Blue Cross Complete member or representative may request an urgent review if waiting the standard review time of 30 days would cause harm to the member's health or life. A request for expedited review must be requested within 10 days of the Adverse Benefit Determination.

If an expedited review is granted, Blue Cross complete will conduct an urgent review within 72 hours after receiving the request. To request an urgent review, call Customer Service, fax 1-800-228-8554.

External review
Blue Cross Complete's decision on the member's appeal is final. If the member disagrees, he or she can request that the state of Michigan conduct an external, or independent review. Public Act 251 (Patient's Right to Independent Review Act) describes this process. The state must receive the member's request within 127 calendar days from the date on the denial letter.

Write to:	Deliver or overnight to:
Department of Insurance and Financial Services	530 W. Allegan Street, 7th Floor
Healthcare Appeals Section	Lansing, MI 48933-1070
Office of General Counsel	Call: 1-877-999-6442
P. O. Box 30220	
Lansing, MI 48909-7720	
Fax: 1-517-241-4168	

(Online): https://difs.state.mi.us/Complaints/ExternalReview.aspx

State Fair Hearing

A Blue Cross Complete member has the right to a Fair Hearing with the state of Michigan. A representative could also request a hearing on behalf of the member. An appeal with Blue Cross Complete must be

completed before a member can request a hearing. Request for a hearing must be made within 120 calendar days from the date on the appeal decision denial notice.

Send request to:

Michigan Administrative Hearing System
Department of Community Health
P.O. Box 30763
Lansing, MI 48909
Call: 1-877-833-0870

A Blue Cross Complete member or representative can request that the same level of benefits continue during the appeal. However, if the appeal is denied, the member may be responsible for payments of benefits received while the appeal was reviewed.

For more information

Members have the right to ask for copies of documents, records and other information used to make decisions, free of charge.

Write:

Member Appeals

Blue Cross Complete
P.O. Box 41789
North Charleston, SC 29423

For dental appeals information, write:

Dental Appeals Coordinator
Blue Cross Complete
P.O. Box 2819
Detroit, MI 48202-3231

For additional assistance and information:
Call the Michigan Department of Health and Human Services
Beneficiary Help Line
1-800-642-3195
TTY: 1-866-501-5656

D. Care within Michigan outside the service area

Limited scope of coverage outside of Michigan

Coverage within Michigan but outside the Blue Cross Complete service area is limited to medical emergencies, urgently needed care and care that can't be provided by an in-network provider.

Emergent care is covered and does not require a referral

Blue Cross Complete members don't need referrals to access emergency, lifesaving care. In a medical emergency, members should go directly to the closest hospital. The facility should notify the member's primary care physician within 24 hours of the emergency admission.

Blue Cross Complete covers post-stabilization care according to Medicaid guidelines. Blue Cross Complete Care Management staff and the primary care physician will arrange for providers affiliated with

Blue Cross Complete to take over the member's care as soon as the member's medical condition and the circumstances allow.

Urgent care is covered

Blue Cross Complete covers needed care provided by in-network and out-of-network providers in an urgent care setting.

E. Blue Cross Complete member rights and responsibilities

Member rights and responsibilities are outlined in member handbook

Blue Cross Complete members have rights, which will be honored by all Blue Cross Complete staff and affiliated providers.

Blue Cross Blue Cross Complete members also have responsibilities.

Member rights and responsibilities are outlined in the **"**Member rights and responsibilities" section of the **Blue Cross Complete Member Handbook**.

The entire member handbook can be accessed online at **mibluecrosscomplete.com.** Select *Core Benefits* in the Member Benefits dropdown and the **Blue Cross Complete Member Handbook** will appear on the page.

Section 9: Managing Noncompliant Care

A. Assisting practitioners in managing noncompliant care

Care management assistance is available for managing noncompliant care

Blue Cross Complete offers care management evaluation services to assist primary care physicians in managing members who are noncompliant with care. Noncompliant behavior may be categorized as follows:

- Drug-seeking behavior
- Fraudulent behavior
- Inappropriate use of outpatient services
- Inappropriate use of the emergency room
- Multiple missed appointments
- Noncompliance with treatment plan

For assistance in managing noncompliant care, practitioners should contact the Blue Cross Complete Integrated Healthcare Management team at 1-888-288-1722 to refer a member for care management evaluation. The following information should be available at the time of the referral:

- Member's name
- Member's phone number
- Member's Medicaid ID
- Reason for referral
- Primary care physician's name
- Primary care physician's office contact name and number

The Care Management team will outreach to the member to evaluate and develops an evaluation and will perform a plan of care. If the member agrees to care management, this plan is shared with both the primary care physician and the member.

B. Special disenrollment from the Medicaid Health Plan

Requests for special disenrollment of a member from the Medicaid Health Plan

Blue Cross Complete may request special disenrollment (termination for cause) of a member from MDHHS under certain circumstances.

Note: Providers don't have the option of disenrolling or removing a member from their practice.

Providers may contact Blue Cross Complete to request the special disenrollment of a member in the following instances:

- In cases of violent, urgent or life-threatening situations involving physical or verbal threats or acts of violence made against Blue Cross Complete providers or staff, or against members of the public at Blue Cross Complete locations

  Note: Before seeking special disenrollment of a member who exhibits violent or threatening behavior, providers must make contact with law enforcement, as appropriate.
- In stalking situations

When special disenrollment is requested, these steps are followed:

1. Blue Cross Complete notifies the member by letter.
2. MDHHS reviews the request.
3. If MDHHS approves the request, MDHHS determines the termination date and notifies Blue Cross Complete.
4. The member has 90 days within which to request a hearing.
5. If a hearing is not requested, MDHHS provides Blue Cross Complete with an electronic termination record. If a hearing is requested, the member remains active until a decision is rendered.

Once a decision has been made, Blue Cross Complete receives a notice from MDHHS indicating either that the member will be terminated (with the termination date) or that the member will not be terminated.

Special disenrollments occur only when they are consistent with the rules and regulations of MDHHS.

All the member's rights to benefits cease as of the effective date of the disenrollment.

Claims for services provided prior to the effective date of the disenrollment are still eligible for reimbursement.

Section 10: Managing Utilization

A. Review of services

Review of services promotes appropriate care

The Blue Cross Complete's Utilization Management (UM) program establishes a process for implementing and maintaining an effective, efficient utilization management system. UM activities are designed to assist the health care professional/provider in the organization and delivery of appropriate healthcare resources to members over the course of the member's illness within the structure of their benefit plan. The primary goal of all utilization management functions is to collaborate with health care professionals/providers, members and other involved health care delivery, to provide quality, cost effective health care in the most appropriate setting for services required.

- UM staff is composed of registered nurses and triage technicians
- Determinations of approval or denial of coverage for services is based on the appropriateness of care, medical necessity, eligibility for outpatient and inpatient services, and benefit guidelines.

Providers have the right to request the information used to make a decision. This includes benefit guidelines or other criteria. To request this information, providers should call the Utilization Management department or write the Appeals Coordinator at the following address:

Appeals Coordinator
Blue Cross Complete
PO Box 41789
Charleston, SC 29423

Utilization Management contact information and hours of operation

Providers can contact Blue Cross Complete's Utilization Management department for plan notification or authorization requests at the toll-free phone number 1-888-312-5713 (press 1 then 4) during normal business hours, which are Monday through Friday, 8:00 a.m. to 5:00 p.m.

Blue Cross Complete recommends that providers use the NaviNet provider portal to submit plan notification and authorization requests. Providers are able to upload clinical information through the portal and view the status of requests they input into in the portal. For additional questions please contact your account executive. Providers may also check authorization requirements of specific codes at mibluecrosscomplete.com/providers/prior-authorization-resources//

After-hours requests

For urgent or emergent requests after normal business hours (Monday through Friday from 5:00 p.m. to 8:00 a.m. and on weekends and holidays), a physician and nurse are available to review requests.

Providers should call 1-888-312-5713 (press 1 then 4) to request an urgent review with the reviewer on call. Telecommunications Device for Deaf/Text Telephone (TDD/TTY) services are available for the hearing impaired by calling the TDD/TTY number 1-888-765-9586.

B. Guidelines for authorization

How to notify the plan or request authorization

Inpatient admissions and certain outpatient procedures must receive prior authorization from Blue Cross Complete's Utilization Management department. The ordering provider or specialists should contact Utilization Management prior to the scheduled admission/procedure to confirm eligibility and secure an authorization if required.

All emergent/urgent inpatient admissions should be reported to Utilization Management by the next business day following admission.

Issue	Guideline
Notifying Blue Cross Complete	Hospitals must notify Blue Cross Complete within 24 hours (one business day) of an urgent/emergent admission. If the member is admitted on the weekend or on a holiday, hospitals must notify Blue Cross Complete on the next business day. Providers or specialists must submit an authorization request for planned inpatient admissions, certain outpatient procedures, and durable medical equipment. Refer to Blue Cross Complete Prior Authorization Request Updates and Lookup Tool to learn more about services that require prior authorization.
Information required when notifying Blue Cross Complete	Blue Cross Complete requires that hospitals submit all pertinent clinical information (history and physical, pertinent labs and imaging findings.)
Blue Cross Complete contact information for submissions	Providers can submit the required information in one of the following ways: • Call 1-888-312-5713 (press 1 then 4) Note: Hospitals can use this number either during or after normal business hours. Normal business hours are 8:00 a.m. to 5:00 p.m., Monday through Friday. • Fax to 1-888-989-0019 • NaviNet provider portal
Blue Cross Complete response time	Blue Cross Complete responds with a determination within the timeframes addressed in the table below.
Action to take after initial notification	Blue Cross Complete requests that hospitals complete concurrent reviews on the next review date communicated by the Blue Cross Complete Clinical Care Review Nurse. It's also requested that all current discharge plans be communicated with concurrent reviews.
What to do if the stay is denied	If denied for medical necessity the attending physician may request peer-to-peer review within five business days. Please follow the peer to peer request process as indicated in section 10B. Reconsideration can be requested withing one business day of the original denial notification. Providers also have the right to appeal a denial (please see section 14 for appeals process).
Notification to the member's primary care physician	Hospitals should notify the member's primary care physician when admitting a member through the emergency room. This notification should take place prior to the member's admission.
Transfer of a member to another facility	Blue Cross Complete will review all requests for transfers to other facilities based on medical necessity.

Members may also request authorization

Blue Cross Complete members may submit requests for authorization of medical care or services. The requests must be submitted either in writing or by telephone.

Standard time frames for all requests for authorization

Blue Cross Complete conducts timely reviews of all requests for authorization according to the type of service requested. Decisions are made according to the following time frames:

Type of Request	Definition	Decision
Preservice urgent	A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state or In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.	Within 72 hours from receipt of request
Urgent concurrent	Requests for coverage of medical care or services that are reviewed as it is provided.	Within 3 calendar days of receipt of request
Preservice non-urgent	A request for coverage of medical care or services that the organization must review in whole or part, in advance.	Within 14 calendar days of receipt of request
Post-service requests	A request for coverage of medical care or services that have been received.	Within 30 calendar days of receipt of request

Extension of authorization time frames

An extension of the standard time frames is allowed if Blue Cross Complete needs more information to make a decision about the request for authorization. Extensions can be requested by phone or mail at:

- 1-800-228-8554 between 8:00 a.m. and 7:00 p.m. Monday through Friday. (TTY users should call 1-888-987-5832.)
- Blue Cross Complete Medical Records
  PO Box 40849
  Charleston, SC 29423

Standard and Urgent Prior Authorizations:

Utilization Management may extend the determination time frame up to fourteen (14) additional calendar days, if:

- The member, provider, or authorized representative requests an extension.
- UM justifies a need for additional information and how the extension is in the member's interest.

Concurrent Reviews (initial and continued inpatient stays):

Utilization Management may extend determination time frames up to 3 calendar days from the date of request, if:

- The member, provider, or authorized representative requests and extension.
- UM justifies a need for additional information and how the extension is in the member's interest.

Retrospective Reviews:

- There is no extension for retrospective reviews.

Note: Providers are asked to submit completed clinical documentation with the initial request. Utilization Management will attempt to reach out to the provider if information is missing – and will make a determination within the required timeframe addressed in the table above.

Requests received later than 180 calendar days from the date of service will be denied for late notification. The attending or treating health care Practitioner, institutional Provider and/or Member are notified of the decision and the reason for the decision.

Authorization is not a guarantee of payment for the service authorized. Blue Cross Complete reserves the right to adjust any payment made following a review of the medical record and determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

Inpatient admissions and discharge planning

Blue Cross Complete's Utilization Management department reviews inpatient admissions and discharge planning to promote high-quality, cost-effective and medically appropriate care.

Blue Cross Complete will respond to verbal requests from emergency departments about post-stabilization services for non-contracted hospitals, including emergency admissions to inpatient care, in one hour or less or the service will be deemed authorized.

Readmissions that occur within 15 days of discharge

Blue Cross Complete's Utilization Management department reviews inpatient readmissions that occur within 15 days of discharge from a facility that is reimbursed by diagnosis-related groups (DRGs), when the member has the same or a similar diagnosis for each admission.

Blue Cross Complete reviews each readmission to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue
- A lack of a discharge plan or inadequate discharge planning
- A planned readmission
- Surgical complications

In some instances, Blue Cross Complete will combine two admissions into one for the purposes of the DRG reimbursement. This is in line with Medicaid policies.

The facility's discharge planning process is a key factor in determining whether the two admissions can be reimbursed separately.

In general, if the facility carried out adequate discharge planning, the patient was stable at discharge and all standards of care were met during the first admission, both the first and second admissions may be deemed separately reimbursable.

Facilities may appeal a decision to combine admissions for payment purposes.

Submission of consent forms

All consent forms must be submitted at the time of the request submission. Abortion forms will be retained for a minimum of ten years.

- Sterilization procedure requests must be submitted with either:
  - An MDHHS Consent for Sterilization form (MSA-1959)
  - An HHS Consent for Sterilization form (HHS-687)
- Voluntary termination procedure requests must be submitted with both:
  - A Certification for Induced Abortion form (MSA-4240)
  - A Beneficiary Verification of Coverage form (MSA-1550)

Peer-to-Peer Requests for Denied Services

If a request for inpatient or outpatient authorization is denied, a peer-to-peer discussion may be requested with the Blue Cross Complete medical director who issued the adverse determination. This request must be from a medical doctor, doctor of osteopathic medicine, nurse practitioner, or physician assistant. The provider requesting can be an ordering provider, treating provider, or a provider familiar with the case. A Peer-to-Peer request will be accepted up to five business days from the date of the original denial.
All Peer-to-Peer requests received within the required timeframe will be returned within three business days.

C. Appealing authorization decisions

Appeal of utilization management decisions for medical necessity

A member, a member representative, or a health care provider acting on behalf of the member, ***with the member's written consent*** may submit an appeal related to an adverse action by Blue Cross Complete, to include a service denial, delay or limitation.

Appeals will be handled and processed within the timeframes listed below:

Type of Appeal	Timeframe to File	Decision
Standard Appeal	Sixty (60) calendar days from the date of the denial notification letter	Within 30 calendar days from Plan receipt of appeal request
Expedited Appeal	Ten (10) calendar days from the date of the denial notification letter	Within seventy-two (72) hours of Plan receipt of appeal request

Note: Blue Cross Complete will expedite an appeal and render a decision within 72 hours of the request if a longer time frame could seriously jeopardize the life or health of the member or would subject the member to severe pain that cannot be adequately managed without the care that is the subject of the request.

A member or practitioner may request that Blue Cross Complete furnish the following:

- All documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision is based

- The names, titles and qualifications of any medical experts whose advice was obtained on behalf of Blue Cross Complete in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision

- Post service appeals - If services have already been provided, please refer to Section 14- Provider Appeals of the provider manual

Filing an extension

Blue Cross Complete may extend the timeframes for Standard Appeals and Expedited Appeals resolution for up to 14 calendar days if the member or member's authorized representative requests the extension, or if Blue Cross Complete shows, (to the satisfaction of MDHHS, upon request) that there is need for additional information and how the delay is in the member's best interest.

State fair hearing

A member, member representative, or healthcare provider acting on behalf of the member, and with member's written consent, can request a State Fair Hearing once Blue Cross Complete's internal appeal process has been exhausted. The State Fair Hearing must be requested within 120 days of Blue Cross Complete's internal appeal determination.

External review

The member, or provider on behalf of the member with the member's written consent, has the right to request an external review by the Department of Insurance and Financial Services. The request must be submitted to DIFS no later than 120 days following the receipt of Blue Cross Complete's determination.

Filing an appeal

The appeal should be submitted as follows:

- By calling Blue Cross Complete Customer Service at 1-800-228-8554
- By writing to:

  Member Medical Appeals
  Blue Cross Complete
  P.O. Box 41789
  North Charleston, SC 29423

- Fax: 1-855-737-9879

State fair hearing

Send your request to:

- Michigan Office of Administrative Hearing and Rules
  Department of Community Health
  P. O. Box 30763
  Lansing, MI 48909

- Call: 1-877-833-0807

External review

Write to:

Department of Insurance and Financial Services
Healthcare Appeals Section
Office of General Council
P.O. Box 30220
Lansing, MI 8909-7720

- Fax: 517-241-4168

D. Utilization monitoring

Blue Cross Complete's Utilization Management department monitors utilization to promote high-quality, cost-effective and medically appropriate care.

Blue Cross Complete uses various mechanisms to monitor and identify potential underutilization and overutilization of services. Each year Blue Cross Complete assesses the characteristics and needs of our diverse member population (including those with special health care needs) using medical and behavioral healthcare data from claims, encounters, laboratory and pharmacy to identify needs. Other examples of data used include socioeconomic, health appraisal and demographic information. This data helps ensure that Blue Cross Complete members receive the medical services required for health promotion and diagnosis, as well acute and chronic illness management. Examples of these mechanisms include:

- Review of Healthcare Effectiveness Data and Information Set (HEDIS) data
- Results of member satisfaction surveys
- Rate of inpatient admissions and length of stay
- Emergency room utilization rates
- Primary care physician and specialty utilization patterns
- Use of non-generic pharmaceuticals
- Mental health utilization data
- Adherence to clinical practice guidelines for preventive health and chronic illness management

Section 11: Managing Care

A. Managing members with an integrated approach

Overview of Integrated Health Care Management program

Blue Cross Complete offers an Integrated Care Management program that provides a population health strategy for comprehensive disease management and complex case management. These services focus on proactive medical care coordination, support and assistance to members with medical, behavioral and social issues that affect their quality of life and their health outcomes.

Blue Cross Complete members are eligible for the program if they have specific health risks due to complex health conditions, require a high level of care coordination and typically access medical services from multiple providers' sites. Members with the following identified issues or diagnoses may be referred to the program:

- Asthma
- Cancer
- Chronic obstructive pulmonary disease
- Congestive heart failure
- Depression management
- Diabetes
- Ischemic heart disease
- Kidney management
- Pregnancy – high risk
- Sickle cell anemia
- Transplants – bone marrow and human organ

Note: This list is not all inclusive.

Both adult and pediatric members are eligible for the Integrated Care Management program. Members who qualify are offered care management services. Enrolled members may choose to opt out at any time.

The Integrated Health Care Management Program is designed to help members understand their condition and achieve and maintain control of their disease. Care Management works collaboratively with the member and the member's primary care physician to promote optimal outcomes of care. Providers who serve members participating in the Integrated Health Care Management Program receive a letter containing information on the member's participation and an explanation of how the program can assist in the collaborative coordination of care.

Members work with a care management nurse

Members who require the services of the Integrated Healthcare Management Program are assigned a nurse who performs both a comprehensive assessment and a disease-specific assessment. Based on these assessments, the nurse identifies the member's problems, goals and barriers to care and develops a collaborative plan of care with the member and the provider. The care manager works in collaboration with the member, the member's family and the physician and the other members of the health care team to

address and resolve the issues the member is facing, to create a care plan and to follow the member's care. Physicians are encouraged to participate in the member's care coordination.

The services provided by the care management team include but are not limited to:

- Member outreach and collaboration
- Contact with the member's providers
- Assistance with scheduling and tracking of appointments
- Assistance with arranging transportation
- Facilitation of member-practitioner communication
- Help in navigating the health care system
- Psychosocial support and connection with various community resources
- Care coordination and transition of care
- And self-management skills

Goals of the Integrated Health Care Management Program

The goals of the Blue Cross Complete Integrated Care Management program are:

- Ensure members have access to the appropriate health care services, health plan benefits and community resources
- Decrease the burden of disease complication through early identification and intervention
- Improve member self-management by providing education and self-management tools
- Increase member compliance with treatment plans through education about the disease process through self-monitoring interventions
- Improve the member's functional status and quality of life
- Coordinate and facilitate health care services
- Assist in communication with the member's primary care physician
- Promote evidence-based treatment guidelines
- Encourage participation in the tobacco use cessation program, as applicable, at no cost to the member

How to refer members to the Integrated Health Care Management Program

Providers can refer members that agree to Integrated Health Care Management for disease, case and complex case management services by calling 1-888-288-1722. When calling to make a referral, providers should have the following information available:

- Member's name, date of birth and enrollee ID number
- Member's address and current phone number
- Reason for member referral
- Name of contact person at the provide office
- Provider phone and fax numbers
- If the office prefers to be contacted by phone or fax with follow up on member outreach activities

B. Collaboration with practitioners

Services offered in collaboration with practitioners

The focus of Blue Cross Complete's Integrated Health Care Management program is the promotion of health and wellness through member education and through collaboration with the member's practitioner.

Based on the types and severity of illness of their members, practitioners may be contacted about referring members for participation in Blue Cross Complete's Integrated Care Management Program.

Blue Cross Complete's Integrated Health Care Management Program is carried out as collaboration between the Blue Cross Complete care manager and the member's practitioner. The care manager works within the practitioner's existing treatment plans for the members involved.

A member's participation in Blue Cross Complete's Integrated Healthcare Management program isn't expected to limit the practitioner's autonomy in providing care to the member enrolled in the programs.

Provider rights and responsibilities when members receive complex case management services

Providers treating members who are participating in Blue Cross Complete's Integrated Care Management Program has the right to:

- Obtain information about Blue Cross Complete, including its programs and services, its staff and its staff qualifications
- Be informed about how Blue Cross Complete coordinates the interventions and plan of care for individual members
- Know how to contact the care manager responsible for managing the case and for communicating with the provider's patients
- Be supported by Blue Cross Complete and work collaboratively in decision-making with members regarding their plan of care
- Receive courteous and respectful treatment from Blue Cross Complete staff and know how to communicate complaints to Blue Cross Complete

Providers are responsible for participating in a member's integrated care management program by:

- Providing relevant clinical information as requested
- Taking action to follow-up on reported information
- Participating in the member's plan of care

Transition of care

Members receiving services from a provider prior to enrollment with Blue Cross Complete are able to continue receiving services for 90 days. This may also include certain prescriptions without prior authorizations. Members must have a relationship with a specialist, primary care provider, or other covered provider prior to enrolling with Blue Cross Complete to establish continuity of care. For more information, view Blue Cross Complete's Transition of care requirements on **mibluecrosscomplete.com**.

C. Pregnancy resources

Educational materials for expectant mothers

Blue Cross Complete offers expectant mothers educational materials about caring for themselves and their new infant.

Blue Cross Complete members can request educational materials on pregnancy, postpartum care and infant care by calling Blue Cross Complete at 1-888-288-1722.

A letter with a link to educational materials is mailed to all identified pregnant members.

Blue Cross Complete members can access additional educational materials on pregnancy, postpartum care and infant care at **mibluecrosscomplete.com** > Maternity Care.

Bright Start program

The Bright Start pregnancy management program promotes healthy behaviors and assists members in controlling risk factors during pregnancy. The ultimate outcome for members is the delivery of healthy, full-term infants who will have a bright start in their lives.

The goals of the Bright Start program are:

- Early identification of pregnant members
- Early and continual intervention throughout pregnancy
- Provision of services designed to encourage members to seek care and follow prenatal protocols
- Care coordination (including transportation) and referral for Maternal Infant Health Program (MIHP) or other home visiting programs such as Nurse Family Partnership, Family Spirit and Healthy Families of America. The Bright Start program is Blue Cross Complete's core maternity management program. Through this program, pregnant members are identified according to their health risk, as follows:
    - Low-risk pregnancy management: Members will receive outreach and pregnancy-related educational materials that encourage good prenatal care.
    - Moderate- and high-risk pregnancy management: Pregnant members identified as being at risk for preterm labor, pregnancy complications or social barriers affecting their prenatal care are assigned a nurse case manager to provide ongoing supervision, coordination of care, education and addressing of various issues throughout the pregnancy. A letter is sent to the member's physician to notify him or her of the member's enrollment in the program.

Provider referral to Blue Cross Complete's pregnancy management services

Providers should call 1-888-288-1722 to refer a Blue Cross Complete member for pregnancy management services through the Bright Start program.

Doula services

Pregnant members are covered for doula services from Medicaid-enrolled doulas, registered with Blue Cross Complete. Doulas provide physical, emotional and educational support. Members can receive up to 12 total visits from a doula during the pregnancy and postpartum periods, and one visit for birth. Doula providers who are seeking reimbursement for providing services to Medicaid beneficiaries are required to be registered and approved on the MDHHS Doula Registry and enrolled in CHAMPS. For information on

how to register with Blue Cross Complete as a doula, providers should call Blue Cross Complete Provider Inquiry at 1-888-312-5713. Providers can refer to the Doula chapter on the MDHHS Medicaid Provider Manual for additional information on enrollment, coverage and reimbursement.

Group prenatal care

Blue Cross Complete provides coverage for professional services associated with in-person, group prenatal care when delivered by accredited Centering Pregnancy™ providers. Centering Pregnancy™ is an evidence-based group prenatal care model that typically includes cohorts of 10 to 12 pregnant individuals within the same gestational period. Individuals are educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception. Educational materials for expectant mothers.

Blue Cross Complete offers expectant mothers educational materials about caring for themselves and their new infant. Blue Cross Complete members can request educational materials on pregnancy, postpartum care and infant care by calling Blue Cross Complete at 1-888-288-1722.

A letter with a link to educational materials is mailed to all identified pregnant members. Blue Cross Complete members can access additional educational materials on pregnancy, postpartum care and infant care at **mibluecrosscomplete.com** > Maternity Care.

D. Rapid Response and Outreach Team

The Blue Cross Complete Rapid Response and Outreach Team address the urgent needs of members and supports Blue Cross Complete providers and their staff. The RROT team consists of registered nurses, social workers and care connectors.

Case managers are also part of the RROT; they provide care management services for members with urgent health concerns that are clinical in nature. Calls are triaged by care connectors and referred to case managers when indicated by an urgent needs assessment or when case management services are requested.

The RROT team offers the following services:

- Inbound call service. Blue Cross Complete members and providers may request RROT support via a direct, toll-free line. The RROT toll-free number is 1-888-288-1722. Referrals to the RROT are also received through the Customer Service department, pharmacy staff, utilization review staff, the retention unit, provider relations staff and other sources. The RROT toll-free number is used as a contact number in all member mailings and automated messaging, when members are encouraged to call for additional support or information. Authorization request are managed by the Utilization Management department (see section 10B – Guidelines for authorization).
- Outreach service. Outreach activities include care gap campaigns, two-way texting, phone surveys, assessment completion and support of special projects or quality initiatives. RROT associates also place outreach follow-up calls related to our ER Diversion Program and to members who have called the 24-hour Nurse Help line and who require additional assistance from case management staff.
- Care coordination: Clinical case managers are available to assist members with their more clinical urgent-immediate needs. Non-clinical support is provided by care connectors who support case managers by providing administrative support to members. This support includes appointment scheduling and reminders, help with transportation arrangements, educational mailings and similar activities. The RROT team assists members with coordinating services provided by community and

social support providers to address member's unmet health-related resource needs and link members to local community resources and social supports.

E. Children's Special Health Care Services

Services available to members enrolled in CSHCS

Blue Cross Complete offers care management and care coordination services for members enrolled in the MDHHS Children's Special Health Care Services program. These members are also eligible to receive coverage for the following medical care and treatment through Blue Cross Complete:

- For children under 21 years old: subspecialty care, therapies and specialized medical equipment and medications for certain diagnoses
- For adults up to age 26 years old, and any age for cystic fibrosis, sickle cell or other hereditary coagulation defects (hemophilia)

The MDHHS CSHCS program provides community-based services for these members that are over and above the services provided by Blue Cross Complete. Information about these services is available at **michigan.gov/mdhhs** > Providers > Providers > Children's Special Health Care Services. The CSHCS program services children and some adults who have special health care needs. The program covers more than 2,700 physical conditions with a specialty referral - regardless of income.

Which providers serve CSHCS members

A subnetwork of Blue Cross Complete primary care providers offers services to the Blue Cross Complete CSHCS population. Providers who qualify to serve these members are selected because they meet the following criteria:

- Provider currently serves children or youth with complex chronic health conditions.
- Provider's practice has a procedure in place to identify children and youth with chronic health conditions.
- Provider's practice offers expanded appointments when the child or youth has complex needs and requires more time.
- Provider's practice coordinates care for children and youth who receive services from multiple professionals (for example, pediatric subspecialists, physical therapists, or mental health professionals).
- Provider's practice is open to new patients (children and youth) with complex chronic health conditions.
- Provider's practice provides services appropriate for Health Care Transition, including but not limited to; the use of a transition readiness assessment tool and adoption of a transition policy that is publicly posted and specifies:
  - the transition time frame
  - transition approach
  - legal changes that take place in privacy and consent at age 18

Practitioners who serve as the primary care provider for the Blue Cross Complete CSHCS population are reimbursed for these additional services on a per-member-per-month basis; $4 to each primary care provider serving a Temporary Assistance for Needy Families (TANF) CSHCS enrollee, $6 to each

primary care provider serving a Healthy Michigan Plan CSHCS enrollees or $8 to each primary care provider serving an Aged, Blind and Disabled (ABAD) CSHCS enrollee.

F. Immunizations

Providers must report child and adult immunizations

Blue Cross Complete requires practitioners to participate in the Michigan Care Improvement Registry, a nationally recognized electronic statewide immunization registry that collects reliable immunization information in Michigan and makes it accessible to authorized users online. Specifically:

- Practitioners are required to report childhood immunizations for children from birth through 19 years of age to the MCIR within 72 hours of administration.

Note: Practitioners are also required to report childhood immunizations to MDHHS.

- Blue Cross Complete practitioners are highly encouraged but are not required to report adult immunizations to the MCIR.

Accessing information and other benefits of reporting to the MCIR

Providers can take advantage of the many benefits that accompany reporting to the MCIR. One of these advantages is that practitioners may access up-to-date information on their patients' immunization histories directly from the MCIR.

Other advantages of reporting immunizations to the MCIR include the following:

- Notifications of immunizations that are coming due and recommendations for future dose dates
- Reminder and recall notices for due or overdue immunizations
- Help with tracking and managing office vaccine supplies, including simplification of the complex immunization requirements and schedules of different manufacturers and combination vaccines
- Official, printer-friendly immunization records for child care and school requirements
- Profiles of practice and patient immunization coverage
- Access to lead screening results and opportunities
- Opportunities for influenza vaccine exchange
- Tracking for immunization hazards and emergency preparedness
- Access to body mass index information

How to register for the MCIR

To access information available through the MCIR, a practitioner must register to become an authorized user. To register for the MCIR, practitioners should contact their MCIR regional office.

Training materials on how to use the MCIR are available at **mcir.org** > **Providers**. The locations of the MCIR regional offices are also available at that location.

Blue Cross Complete uses MCIR information

Blue Cross Complete receives immunization data from the MCIR and uses them along with data from other sources, including other physician-reported data and medical claims, to supplement the reports to providers available through NaviNet, a clinical support tool for primary care physicians.

Participating providers assist in outreach

When individual practitioners participate fully in reporting both childhood and adult immunizations to the MCIR, they're assisting with the public health all-hazard tracking system that supports emergency preparedness on a local and national basis. Through the MCIR, local health departments do population-based assessments of immunization levels and focus outreach efforts where they're most needed.

Additional information about the MCIR

Additional information about the MCIR is available at **mcir.org.**

Vaccination waivers

The State of Michigan's Joint Commission on Administrative Rules approved waiver rules for parents who want an exception from vaccinations for their children.

The rules require parents who want a nonmedical waiver to receive education regarding the benefits of vaccination from a county health department before obtaining the waiver.

Additional information about the requirements is available at **michigan.gov** > State Departments > Health and Human Services > Pregnant Women, Children & Families > Children & Families > Immunization Info for Families & Providers > Health Care Professionals/Providers > **Immunization Waiver Information**.

G. Nurse Help line (for members)

All members can use the Nurse Help line

All Blue Cross Complete members have access to a 24-hour toll-free Nurse Help line at **1-888-288-1724**.

H. Kidney Management

Chronic kidney disease or end state kidney disease

Blue Cross Complete offers a specialized program for eligible members who have or are at risk of developing chronic kidney disease or end-stage kidney disease.

In collaboration with health care providers, members can receive additional support in managing their kidney disease and adhering to treatment plans. Practitioners may be contacted about referring members for participation. To learn more about the program, contact Integrated Health Care Management Program at 1-888-288-1722.

I. Recuperative Care

Blue Cross Complete offers recuperative care coverage for members who are homeless individuals aged 18 and older.

Recuperative care program is a short-term, transitional program for eligible Medicaid members experiencing homelessness and discharge from an inpatient hospital admission. These members are too ill or frail to return to their living environment but are not eligible to continue hospital-level care, skilled nursing care, or other inpatient Medicaid services. The recuperative care program allows members to recover post-hospitalization, receive case management and supportive services, and access medical care or other Medicaid services.

The attestation can be submitted through NaviNet or via fax to 1-888-989-0019. When submitting the form, please use the following episode details:

- Outpatient Episode Type
- Standard/Elective TAT
- Code: G9002
- Start Date: RFC admission date from form
- End Date: RC anticipated discharge date from form
- Units: Count the calendar days between the admit/discharge date
- Decision: Approval
- Decision Reason: Intake Specialist Approval

Note: the following will result in an administrative denial:

- Approval not clear (a definitive approval not indicated)
- Denial indicated
- Unable to issue
- Member not eligible

Once the attestation form is submitted, the provider will receive a response from Blue Cross Complete's Utilization Management team within 14 business days, that includes the following:

a. Approval information
b. Case authorization # (Cert #)
c. Procedure code(s) approved/denied
d. Dates of service covered under the authorization/or DOS

If providers have additional questions regarding the authorization contact the regional Blue Cross Complete Provider Account Executive. For full details on RC provider enrollment, prior authorization and eligibility, review MDHHS bulletin number MMP 24-27, available at michigan.gov.

Section 12: Pharmacy Services

A. Prescription drug program overview

Description of pharmacy coverage

Blue Cross Complete members have pharmacy coverage as follows:

Formulary

- Blue Cross Complete participates in the Michigan Managed Care Common Formulary. Additional information regarding the common formulary can be found on our website at mibluecrosscomplete.com and at michigan.gov/mcopharmacy.
- Medications included on the common formulary are listed as *preferred* or *non-preferred*. Before approving any non-preferred medication, members must meet prior authorization criteria. Exceptions may be made if preferred medications are inappropriate for treating the member's condition. Non-formulary medications must meet drug/class specific criteria or meet medical necessity criteria.
- Drugs which require prior authorization are identified on the *Blue Cross Complete Preferred Drug List*. *The Blue Cross Complete online prior authorization submission form* is available at mibluecrosscomplete.com. *The Blue Cross Complete prior authorization fax form* is available at **mibluecrosscomplete.com**. Criteria may change from time to time. Drugs that require prior authorization are covered only if Blue Cross Complete authorizes coverage. To request prior authorization for these medications, providers should contact the PerformRx Clinical Specialty Pharmacy Help Desk at 1-888-989-0057.
- With the exception of maintenance drugs, all prescriptions are limited to a maximum of a 34-day supply. The maintenance drug list can be accessed at **michigan.magellanrx.com** > Provider Portal > Documents > Other Drug Information > Maintenance Drug List. Drugs included in the therapeutic class list on the Maintenance Drug List document are eligible for up to a maximum of a 102-day supply. The maintenance drug list is also available by accessing mibluecrosscomplete.com > Member Benefits > Pharmacy Benefits > Preferred drug list > Maintenance Drug List (PDF).
- Oral contraceptives are allowed to be dispensed for up to a maximum of a 12-month supply as required under MDHHS Health and Aging Services Administration Bulletin 22-12.
- In order for a prescription to be considered for coverage, the prescriber and the pharmacy must be active in CHAMPS. Provider enrollment information is available at michigan.gov/mdhhs. A pharmacy within the Blue Cross Complete pharmacy network must be used. Although exceptions can be made in emergency situations when a prescriber has yet to enroll, or has enrolled and hasn't yet been included in a system update, no exception can be made for a pharmacy which isn't enrolled in CHAMPS.
- Drugs that are excluded from coverage by the state of Michigan's Medicaid program aren't covered for Blue Cross Complete members unless otherwise included on the Common Formulary or Enterprise Formulary. These excluded drugs include drugs used for cosmetic purposes, infertility, sexual dysfunction and symptomatic relief of cough and cold; bulk powders for compounded products; food supplements; and certain vitamin preparations.
- Drugs that are part of the Medicaid Health Plan Carve-Out (Michigan Medicaid) must be processed through Magellan and aren't payable through Blue Cross Complete. These include anticonvulsants, antidepressants, monoamine oxidase inhibitors, anti-anxiety agents, sedative/hypnotics, CNS

stimulants, antiretrovirals, antivirals for hepatitis C, disulfiram, naltrexone HCL, acamprosate calcium, buprenorphine HCL, and other drugs.

- Note: The full list of drug classes included in the Medicaid Health Plan Carve-Out (Michigan Medicaid) can be accessed at michigan.magellanrx.com/ > Provider Portal > Documents > Carveout Coverage > Medicaid Health Plan Carveout.

Pharmacy network

- Specialty medications are available through the mail from Perform Specialty Pharmacy or another specialty pharmacy in the pharmacy network. The prior authorization department will assist with selection. Some specialty medications (i.e. limited distribution drugs) must be dispensed from approved pharmacies only.
- No mail-order drug benefit is available for Blue Cross Complete members for non-specialty drugs.

About the Blue Cross Complete Preferred Drug List

The *Blue Cross Complete Preferred Drug List* identifies drugs that are covered for Blue Cross Complete members. Although the Preferred Drug list is comprehensive for formulary medications, it doesn't include all available drugs on the market.

The MDHHS MCO Common Formulary Workgroup and, when compliant with the Common Formulary requirements, the Blue Cross Complete Pharmacy and Therapeutics Committee may add or remove drugs from the *Blue Cross Complete Preferred Drug List* during the year. These changes are published as part of a Pharmacy Formulary update document located at mibluecrosscomplete.com.

The *Blue Cross Complete Preferred Drug List* is available online at mibluecrosscomplete.com in PDF form. With the exception of maintenance drugs, all prescriptions are limited to a maximum of a 34-day supply unless otherwise specified on the formulary. The pharmacy documents are reviewed and updated monthly or as necessary. Providers can also access the Online Searchable Formulary linked to this website.

Blue Cross Complete encourages physicians to refer to the *Blue Cross Complete Preferred Drug List* when considering drug therapy for Blue Cross Complete members.

Additional information regarding the MDHHS MCO Common Formulary may be accessed by visiting michigan.gov/mcopharmacy Plan information, prior authorization criteria, and step therapy criteria are also available on this site. Resources are also available for MDHHS Preferred Drug List classes and coverage details by visiting michigan.magellanrx.com/provider.

Over-the-counter coverage

Select over-the-counter pharmaceuticals are covered with a prescription. Covered over-the-counter items include, but may not be limited to, pain relievers (acetaminophen and aspirin), laxatives and antacids, antihistamines, calcium, condoms, contraceptive gel products, iron and generic prenatal vitamins. Blue Cross Complete also provides coverage for selected diabetic medical supplies in the retail pharmacy, including disposable insulin needles and syringes, lancets, test strips and alcohol swabs. For details, providers should refer to the *Blue Cross Complete Preferred Drug List*.

Coverage for tobacco use cessation products

Over-the-counter agents (patches, gum and lozenges) and non-nicotine medications used to promote tobacco use cessation are included on the *Blue Cross Complete Preferred Drug List*. Members may also call the Tobacco Quitline program at 1-800-784-8669 for additional support.

Generic substitutions

Unless otherwise specified, generic substitution is required when an equivalent generic drug is available and appropriate. If brand is not preferred according to formulary rules, prior authorization is required for coverage of brand-name products for which generic equivalents are available. For a list of drugs where the brand name medication is required, please refer to the *Blue Cross Complete Preferred Drug List* or visit michigan.magellanrx.com/provider/documents and view the Fee-For-Service *Brand Preferred Over Generic Products List* under the Other Drug Information heading.

Coverage for brand-name drugs

Unless preferred on the formulary, brand-name drugs that are available as generics but that physicians prescribe, or members request to be dispensed as written (DAW), are non-formulary and are not covered.

DAW requests may be considered for coverage if a serious event or a quality issue occurred while trying the covered generic version. The request must be determined to be medically necessary by the physician and approved by Blue Cross Complete. The physician must submit a completed *MedWatch* form to the FDA to document serious adverse events or a quality issue with the covered generic. A copy of the completed *MedWatch* form must also be included with the *Blue Cross Complete Medication Prior Authorization Request* form, found at mibluecrosscomplete.com.

Information regarding the FDA's MedWatch Program and the related online forms are available at the FDA's MedWatch Program website at fda.gov/medwatch.

Coverage for drugs not included on the Blue Cross Complete Preferred Drug List

The *Blue Cross Complete Preferred Drug List* is a subset of drugs that are eligible for coverage under the Medicaid benefit. Drugs not included may be non-formulary or may be excluded from coverage by the state of Michigan and not covered. Some drugs may be considered for coverage based on medical necessity, as determined by the physician and Blue Cross Complete. To request coverage for a non-formulary drug, providers should contact the PerformRx Clinical Pharmacy Help Desk at 1-888-989-0057.

B. Drug authorization guidelines

Prior authorization requirements for drugs

Drugs that require prior authorization are identified as such on the *Blue Cross Complete Preferred Drug List*. Prior authorization helps ensure that safe, high-quality, cost-effective drug therapy is prescribed prior to the use of more expensive agents that may not have proven value over the current formulary medications. The criteria for approval are based on current medical information and are approved by the MDHHS MCO Common Formulary Workgroup, MDHHS Fee For Service Medicaid Pharmacy and Therapeutics Committee, and the Blue Cross Complete Pharmacy and Therapeutics Committee. If a drug requires prior authorization, either certain clinical criteria must be met, including previous treatment with formulary agents, or other information must be provided before coverage is approved.

How to request prior authorization for drugs

Blue Cross Complete considers requests for prior authorization based on medical necessity. To request prior authorization or an override of one of Blue Cross Complete's drug utilization management tools, Blue Cross Complete providers may use one of the following methods:

- Complete and submit the online *Blue Cross Complete Medication Prior Authorization Request* form found at mibluecrosscomplete.com.

- Complete and submit the PDF version of the *Blue Cross Complete Medication Prior Authorization Request* form found at mibluecrosscomplete.com.

Note: The fax number is shown on the form.

- Contact the PerformRx Clinical Specialty Pharmacy Help Desk at 1-888-989-0057.

Note: This number is available to providers 24 hours a day, seven days a week, including holidays.

Providers will need to provide documentation regarding the reason a formulary alternative is not appropriate for the member. If the request is for a higher quantity of a medication than Blue Cross Complete allows, the provider must provide documentation showing that the allowed quantity is not adequate for the member's condition.

Authorization requests that do not include documentation of medical necessity or failure of or intolerance to formulary alternatives will not be considered for coverage.

Responses to requests for coverage determinations are made within 24 hours unless additional information is needed.

How to make urgent requests for prior authorization for drugs

Providers should alert the PerformRx Clinical Specialty 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 the member would be subjected to severe pain that cannot be adequately managed, in the opinion of the prescriber with knowledge of the member's condition.

Providers should consider these criteria when providing documentation if the request is urgent. A response to these requests will be provided within 24 hours.

C. Appealing a decision to deny authorization of drugs

Providers can appeal a decision to deny authorization of drugs

When a request for prior authorization of formulary drugs or approval of non-formulary drugs is denied, providers can submit an appeal on behalf of the member that is specific to the denial being appealed, with the written permission of the member. Pharmacy appeals will follow the same timeline and process as the UM appeals referenced in section 10B. The appeal should be submitted as follows:

- By calling Blue Cross Complete Customer Service at 1-800-228-8554
- By writing to:

  Blue Cross Complete
  P.O. Box 41789
  North Charleston, SC 29423
- By faxing to 1-866-900-4482

D. Drug exclusions

Which drugs are not covered

Drugs that are **not** covered by Blue Cross Complete may include the following:

- Over-the-counter drugs that are not on the *Michigan Pharmaceutical Product List.*

- Drugs used for the symptomatic relief of cough and colds. (Select codeine- and non-narcotic-containing products are covered.)
- Cosmetic drugs or drugs used for cosmetic purposes.
- Drugs used for infertility.
- Drugs used for sexual dysfunction.
- Drugs used for anorexia.
- Food supplements and standard infant formulas.
- Drugs that aren't approved by the FDA.
- Drugs used for experimental or investigational purposes.
- Drugs prescribed specifically for medical studies.
- Prescriptions filled after a member is no longer enrolled in Blue Cross Complete.
- Prescriptions that extend more than 34 days beyond a member's Blue Cross Complete termination date.
- Drugs included as a health care benefit and other injectable drugs that are normally administered in a physician's office. Note: seasonal influenza vaccines and other select vaccines are covered at participating retail pharmacies.
- Drugs covered by another plan, including Medicare Part D.
- New drugs not yet reviewed by the Michigan Common Formulary Workgroup and the Blue Cross Complete Pharmacy and Therapeutics Committee.
- Drugs recalled by the manufacturer and discontinued drugs.
- Drugs acquired without cost to the providers or included in the cost of other services or supplies.
- Durable medical equipment and supplies, such as certain blood glucose monitors and ostomy supplies. (These are covered under the medical certificate.)
- Drugs shown on the *Medicaid Health Plan Carve-Out (Michigan Medicaid)* list at michigan.magellanrx.com> Provider Portal > Documents > Carveout Coverage > Medicaid Health Plan Carveout. (Coverage is provided by the state of Michigan.) This includes drugs used in the treatment of substance abuse disorders.
- Compounded products that contain bulk powders, unless medically necessary. Must be approved through the prior authorization process.
- Compounded products that contain excluded ingredients are also excluded from the benefit.
- Prescriptions that have been adulterated or are fraudulent.

E. Additional pharmacy information

Blue Cross Complete pharmacy network

Members are encouraged to use a Blue Cross Complete network pharmacy which participates in the Blue Cross Complete pharmacy network. The Blue Cross Complete pharmacy network is available online at mibluecrosscomplete.com.

Prescribers must use tamper-resistant prescription pads with NPI

Prescribers affiliated with Blue Cross Complete are required to include their NPI on prescriptions for Blue Cross Complete members. The use of these pads helps avoid service delays at the point of sale when dispensing pharmacies ask for the prescriber's NPI. The pharmacies are required to include the prescriber's NPI on prescription claims submitted for Blue Cross Complete members. Dispensing pharmacies may require that all prescriptions for Blue Cross Complete members be written on tamper-resistant prescription pads in order to process them.

The requirements for tamper-resistant prescription pads and inclusion of the NPI are associated with federal and state regulations that affect prescriptions written for Blue Cross Complete members. The requirement for tamper-resistant prescription pads does not apply to prescriptions ordered via telephone or fax, or to electronic prescriptions.

Only specialty medications are available by mail

There is no mail-order drug benefit for Blue Cross Complete members other than for specialty drugs.

Medications for dual-eligible members

For dual-eligible members (those members with Original Medicare, BCN Advantage or Medicare Plus Blue PPO as their primary plan and Blue Cross Complete as their secondary plan), providers should consult the applicable Medicare Part D formulary first.

Medications which are not covered under the Medicare plan's formulary may be covered under the Blue Cross Complete formulary as an exception. Exceptions include select formulary Over-The-Counter drugs. Medications included in the Medicaid Health Plan Carve-Out (Michigan Medicaid) list are not covered by Blue Cross Complete under any circumstance.

Prescription drug monitoring program requirement for providers

Michigan Medicaid providers who prescribe a controlled substance are required to check the Michigan Automated Prescription System for the beneficiary's 12-month prescription drug history before prescribing controlled substances. MDHHS announced this in bulletin number MSA 21-30, available at michigan.gov.

Documentation of the required MAPS check should be kept in accordance with the Medicaid record retention policy. Exemptions to this requirement include:

- Beneficiaries who are receiving cancer treatment or hospice/palliative care in long-term care facilities described in 1396d of Title XIX or other facilities with single pharmacy contract.
- Prescriptions provided during declared natural disasters or emergency services.

Providers with questions should call MDHHS at 1-800-292-2550 or email MDHHS Provider Inquiry at **ProviderSupport@michigan.gov**. Be sure to include your name, affiliation, NPI number and phone number.

Additional information about pharmacy services

Additional information about the Blue Cross Complete Pharmacy program is available at mibluecrosscomplete.com.

Section 13: Claims

A. Claims overview

Claims processing overview

Blue Cross Complete processes claims according to Michigan Uniform Billing Guidelines.

Information specific to Blue Cross Complete claims is found in this section of the *Blue Cross Complete* manual.

Regular updates on processing information are available via NaviNet, messages on Blue Cross Blue Shield of Michigan's Provider Secured Services Availity provider portal and in Blue Cross Complete provider newsletters.

Members cannot be held liable

Blue Cross Complete members are not to be held liable for claims related to covered Blue Cross Complete services.

Reimbursement follows Medicaid fee schedules

Blue Cross Complete reimbursement follows the Medicaid fee schedules, which can be accessed at **michigan.gov/providers** > Providers > Medicaid > Billing and Reimbursement > **Provider Specific Information**.

Claims from out-of-state, providers, if authorized, are paid according to the established Medicaid fee schedule in effect on the date of service. If you are a provider or facility outside of the State of Michigan and aren't participating with Blue Cross Complete, please submit all claims through your local Blue Cross plan (for Blue Card access).

All providers are required to follow the authorization guidelines. The list of services requiring prior-authorization can be found on our website **mibluecrosscomplete.com/providers/resources**.

Resources for providers

The following resources are available to providers for verifying a member's eligibility and claims status:

- NaviNet (for checking member eligibility and claims status)
- BCBSM's Availity provider portal (for checking member eligibility)

Note: Blue Cross Complete Remittance Advice statements are posted in Availity under the *View Electronic Vouchers* page; they aren't with the NASCO statements. Links to the Remittance Advice statements don't show "EFT" or "NON-EFT.".

Follow contract requirements

Physicians should always follow the requirements listed in their Blue Cross Complete provider contract. If any information in this manual differs from the provider contract, the contract language prevails.

Time limit for filing claims

- **Claims:** The filing limit for submitting a new claim is 12 months from the date of service or discharge date.
- **Resubmissions:** Blue Cross Complete follows MDHHS guidelines for Resubmitted and corrected claims. All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from date of service.

Claims that receive a front-end rejection, whether submitted electronically or on paper, are not considered submitted or clean claims. To be considered submitted or clean, a claim must contain all required data elements in the appropriate format. Claims that receive a front-end rejection must be corrected and resubmitted within the standard filing limit time frames. A copy of a front-end rejection is not acceptable documentation of a claim submission for payment reconsideration purposes.

Exceptions can be made to the timely filing billing limitation policy in the following circumstances:

- Blue Cross Complete administrative error occurred, including:
  - The provider received erroneous written instructions from Blue Cross Complete staff
  - Blue Cross Complete staff failed to enter (or entered erroneous) authorization, level of care, or restriction in the system
  - Other administrative errors by Blue Cross Complete that can be documented
- Medicaid beneficiary eligibility/authorization was established retroactively
- Primary insurance taking back payment after timely filing limitation has passed.
  - The provider must submit a copy of the insurance letter of EOB from the primary insurance showing the date money was taken back from paid claim.
  - The claim must be submitted to Blue Cross Complete within 120 days of the primary insurance letter or remit date.

Retroactive provider enrollment with Blue Cross Complete isn't considered an exception to the timely filing billing limitation.

B. General guidelines for filing claims

Professional and facility claims: how to file

- Submit claims through electronic data interchange (EDI) allows faster, more efficient and cost-effective claim submission for providers. It has also been proven to reduce claim re-work (adjustments). Therefore, it is preferred that all claims be submitted electronically.
- Physicians can bill on the CMS-1500, Facilities on the UB-04 claim form, as appropriate. These forms, produced by the Centers for Medicare & Medicaid Services, are used nationally.
- All NPIs submitted on a claim are checked against MDHHS CHAMPS for eligibility. Any claim with a NPI that is not active on the DOS according to MDHHS CHAMPS will be denied accordingly.

Professional claims referring/ordering provider

- Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s).

- The referring/ordering provider cannot be the same as the rendering provider. In the event where the referring and rendering provider are the same, box 17 on the CMS 1500 form (referring provider) is not a required field and may be left blank.
- In the absence of a referral/order, the referring provider field may be left blank.

UB claims providers

- This applies to all providers on a UB claim form, including attending, ordering, referring, supervising, and operating.
- When billing on a UB claim form, the providers listed on the claim must be submitted with a valid provider type and unique NPI that is allowable for the bill type. Effective January 1, 2022, the attending, ordering, referring, supervising, and operating provider(s) must be a provider type that is allowable per MDHHS rules, which are available at michigan.gov.
    - Inpatient bill types: michigan.gov
    - Outpatient bill types: michigan.gov
- If any of these data elements are missing, invalid or the NPI isn't active with MDHHS CHAMPS, the claim may be denied.

Information required for all claims

Field formats may vary. Software vendors have instructions for entering the information for electronic claims.

- A Place of Service code must be provided on each CMS-1500 claim. A list of the Place of Service codes is available on the CMS website at **cms.gov** > Medicare > **Place of Service Codes** (under the Coding heading).
- Claims submitted on a CMS-1500 must have a physical address in box 33 of the claim. PO Boxes are not allowed to be billed in box 33 per MDHHS rules.
- Claims must be billed with valid procedure and/or revenue codes, modifiers and diagnosis codes. If any of these data elements is missing or invalid, the claim may be denied. Physicians should ensure that any procedure code and modifier combinations submitted are appropriate and that multiple modifiers are used when applicable.
- The National Drug Code (NDC), Unit of Measure and Units supplied are required for all drugs as indicated by MDHHS policies.
- Claims must be submitted with the correct member information. For both electronic and paper claims, the following member match criteria rules are in effect:
    - Claims can be submitted with either the member's Blue Cross Complete ID number or the member's Medicaid ID number.
    - Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers must always submit claims to Blue Cross Complete using the member's Medicaid ID.
    - Blue Cross Complete does not match if a Social Security number is submitted as the contract number. These claims are rejected as contract number not found.
    - An exact match on the date of birth is required.
    - Blue Cross Complete uses enhanced logic if there's more than one match (twin logic). The full first name will be used. If there are still two matches, the relationship code will be used.
    - Spaces, hyphens and other special characters are ignored when matching on name.

C. Filing claims electronically

Preparing to file claims electronically

Submit claims through electronic data interchange (EDI) for faster, more efficient claims processing and payment. Providers may submit electronic claims via Optum/Change Healthcare or Availity clearinghouses. The main options for the electronic handling of claims are as follows:

- The HIPAA 837 electronic standard transaction is used for submitting a new claim and for correcting or replacing a claim already submitted.
- The HIPAA 835 electronic standard transaction is the electronic Remittance Advice, which shows how the claim was paid.

Before filing electronically, providers should call Optum/Change Healthcare at 1-800-527-8133 or Availity Client Services at 1-800-282-4548. An agent will help each provider navigate the process and confirm that the provider's software vendor is approved to bill Blue Cross electronically.

Providers can also follow the guidelines for electronic billing that are available in the reference documents at **mibluecrosscomplete.com**.

Guidelines for filing claims electronically

Blue Cross Complete claims must adhere to specific guidelines. To ensure proper handling of Blue Cross Complete claims, remember these key requirements:

- For members with an enrollee ID beginning with XYU, report the entire contract number including the prefix in loop 2010BA NM109
- For members with a 10-digit Medicaid recipient ID, report the full 10 digits without spaces or special characters in loop 2010BA NM109
- All Blue Cross Complete claims must report a claim filing indicator/source of payment code 'HM' in loop 2000B SBR09
- Professional claims must report payer ID 00710 in loop 2010BB NM109
- Institutional claims must report payer ID 00210 in loop 2010BB NM109

Following up on EDI claims via the HIPAA 276/277 standard electronic transaction

Providers who submit claims electronically can use the HIPAA 276/277 standard electronic transaction (Claim Status Inquiry and Response) to check the status of a claim.

For additional information about the HIPAA 276/277 standard electronic transaction, providers should contact Availity at 1-800-282-4548, or Optum/Change Healthcare at 1-800-527-8133.

D. Filing paper claims

Guidelines for filing paper claims

For claims that may be filed on paper, providers should follow these guidelines:

- File claim on a red and white CMS-1500 or UB-04 form.
- Use 12-point readable type (Arial or Times New Roman).
- Do not submit handwritten claims.
- Use black ink that produces a clear impression. Each character must be distinct.

- Do not use highlighters or any other markers on the claim or on any attachments to the claim. They make the claim impossible to process.
- Do not use an imprinter to complete any portion of the claim form. The forms are not designed for use with an imprinter.
- Use a six-digit format with no spaces or punctuation for all dates; for example, enter May 3, 2008 as 050308.
- Securely staple all attachments. Paper clips or tape tend to fall off. Send only Medicare or coordination of benefits information. No other attachments are necessary.
- Use large, flat envelopes (instead of folding claims into letter-size number 10 envelopes). This significantly improves Blue Cross Complete's processing time and reduces the chance of damage to the paper form.
- Complete all required data fields on the form. Incomplete claims will be returned. Leave the field blank if there is no information to populate that field.
- Use only code sets required by HIPAA regulations.
- Ensure data are enclosed within field or box perimeters, including the provider signature. Claims with text or data outside field or box perimeters will be returned for alignment rejection.
- Include the name and the NPI for the billing provider in field 33a. Claims will be returned if the NPI is missing from field 33a of the CMS-1500 form.
- Include the NPI of the rendering physician in field 24j (unshaded) on the CMS-1500 form. This is particularly important if the NPI in box 33a is for a group.
- Always include the tax identification number in box 25.
- Report the member's correct Medicaid ID number, as shown on the member's ID card. Include the suffix and the date of birth.
- Report any other insurance information when submitting the claim.
- Submit paper claims to:

  Blue Cross Complete Claims
  P.O. Box 7355
  London, KY 40742-7355
- If you are a provider or facility outside of the State of Michigan and are not participating with Blue Cross Complete, please submit all claims through your local Blue Cross plan (for Blue Card access).

E. Processing submitted claims

Prompt payment legislation

Claims received by Blue Cross Complete will be processed in accordance with prompt payment legislation (Public Act 28 of 2004). This means that Blue Cross Complete is required to pay simple interest at 12 percent per year on all "clean claims" that are not paid within 45 days of receipt.

What is a clean claim?

Public Act 28 defines clean claims as claims that:

- Identify the provider of services (Blue Cross Complete requires the provider's NPI(s) and tax identification number as the identifiers.)
- Identify the member and subscriber
- List the date and place of service
- Bill for covered services for eligible members
- Substantiate the medical necessity and appropriateness of care, when necessary
- Contain prior authorization or precertification information, when necessary
- Identify services rendered using proper procedure and diagnosis codes
- Include any necessary additional information as required by Blue Cross Complete

Remittance advice statements

After Blue Cross Complete processes a claim, a remittance advice (also called a claim voucher) is issued that tells the provider about the claim's payment status. The remittance advice is a detailed summary disposition of the claims. Blue Cross Complete claims are shown on a remittance advice that carries the Blue Cross Complete logo and reflects only Blue Cross Complete claims.

The ASC X12 Health Care Information Status Notification (277) electronic standard transaction

Refer to the Availity EDI Batch Guide/EDI Reporting Preferences application to begin receiving either the Transaction or report.

The 277CA transaction or report identifies which claims have been edited and will not continue on for processing.

Tips for using the 277CAP transaction

On the 277CAP transaction, providers can distinguish between an edit for "member not found" and one for "contract not found" as follows:

An edit for member not found returns as A3:26:QC.

- A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
- 26 – Entity not found. Note: This code requires use of an entity code.
- QC – Patient

An edit for contract not found returns as A3:164:HK.

- A3 – Acknowledgement / returned as claim not able to process. The claim/encounter has been rejected and has not been entered into the adjudication system.
- 164 – Entity's contract/member number. Note: This code requires use of an entity code.
- HK – Subscriber

Paper claims that do not meet HIPAA 5010 X12 format requirements

Blue Cross Complete will convert paper claims data into an electronic claim as set forth by the United States Department of Health and Human Services and HIPAA standards.

Note: Paper claims that are completed improperly will be rejected.

Please refer to the grids below for both the CMS-1500 and UB-04 required fields and billing guidelines for mandated 5010 837 formats to ensure your claims are submitted correctly.

Field #	CMS-1500 Field/Data Element	"Reject Statement" (Reject Criteria)
2	Patient's Name	"**Member name is missing or illegible.**" (If first or last name are missing or illegible, the claim will be rejected.)
3	Patient's Birth Date	"**Member date of birth is missing.**" (If missing month or day or year, the claim will be rejected.)
3	Patient's Birth Sex	"**Member's sex is required.**" (If no box is checked, the claim will be rejected.)
4	Insured's Name	"**Insured's name missing or illegible.**" (If first or last name is missing or illegible, the claim will be rejected.)
5	Patient's Address (number, street, city, state, zip) phone	"**Patient address is missing.**" (If street number, street name, city, state or zip are missing, the claim will be rejected.)
6	Patient Relationship to Insured	"**Patient relationship to insured is required.**" (If none of the four boxes is selected, the claim will be rejected.)
7	Insured's Address (number, street, city, state, zip) phone	**"Insured's address is missing.**" (If street number, street name, city, state or zip are missing, the claim will be rejected.)
21	Information related to Diagnosis/Nature of Illness/Injury	"**Diagnosis code is missing or illegible.**" (The claim will be rejected.)
24	Supplemental Information	"**National Drug Code data is missing or incomplete or invalid.**" (The claim will be rejected if NDC data is missing incomplete or has an invalid unit/basis of measurement.)
24A	Date of Service	**"Date of service is missing or illegible.**" (The claim will be rejected if both the "From" and "To" DOS are missing. If both "From" and "To" DOS are illegible, the claim will be rejected. If only the "From" or "To" DOS is billed, the other DOS will be populated with the DOS that is present.)
24B	Place of Service	"**Place of service is missing or illegible.**" (Claim will be rejected.)
24D	Procedure, Services or Supplies	"**Procedure code is missing or illegible.**" (Claim will be rejected.)
24E	Diagnosis Pointer	"**Diagnosis pointer is required on line ___" [lines 1-6].** (For each service line with a "From" DOS, at least one diagnosis pointer is required. If the DX pointer is missing, the claim will be rejected.)
24F	Line item charge amount	"**Line item charge amount is missing on line ___" [lines 1-6].** (If a value greater than or equal to zero is not present on each valid service line, claim will be rejected.)
24G	Days/Units	"**Days/units are required on line ___" [lines 1-6].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, claim will be rejected.)
24J	Rendering Provider identification	**"National provider identifier of the servicing or rendering provider is missing or illegible."** (If NPI is missing or illegible, claim will be rejected.)
25	Federal Tax I.D. Number SSN/EIN	**"Billing Provider Tax ID is missing or incomplete" (**If the provider tax ID is missing the claim will be rejected.)

Field #	CMS-1500 Field/Data Element	"Reject Statement" (Reject Criteria)
26	Patient Account/Control Number	"**Patient Account/Control number is missing or illegible**" (If missing or illegible, claim will reject)
27	Assignment Number	"**Assignment acceptance must be indicated on the claim.**" (If "Yes" or "No" is not checked, the claim will be rejected.)
28	Total Claim Charge Amount	"**Total charge amount is required.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
31	Signature of physician or supplier including degrees or credentials	**"Provider name is missing or illegible."** (If the provider name, including degrees or credentials, and date is missing or illegible, the claim will be rejected.)
33	Billing Provider Information and Phone number	"**Billing provider name and/or address is missing or incomplete.**" (If the name and/or street number and/or street name and/or city and/or state and/or zip +4 are missing, the claim will be rejected.)
33	Billing Provider Information and Phone number	**"Field 33 of the CMS1500 claim form requires the provider's physical service address."** (If a PO Box is present, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
1	Billing Provider Name, Address and Telephone Number	"**Billing provider name or address missing or incomplete.**" (If the name, street number, street name, city, state or zip +4 code is missing, the claim will be rejected.)
1	Billing Provider Name, Address and Telephone Number	"**Field 1 of the UB04 claim form requires the provider's physical service address."** (If a PO Box is present, the claim will be rejected.)
3a	Patient Account/ Control Number	"**Patient account/control number is missing or illegible.**" (If the number is missing or illegible, the claim will be rejected.)
5	Fed. Tax Number	**"Billing Provider Tax ID is missing or incomplete" (**If the provider tax ID is missing the claim will be rejected.)
8b	Patient Name	"**Member name is missing or illegible.**" (If first or last name are missing or illegible, the claim will be rejected.)
9a-e	Patient Address	"**Patient address is missing.**" (If the name, street number, street name, city, state or zip +4 code is missing, the claim will be rejected.)
10	Patient Birth Date	"**Member DOB is missing.**" (If month, day or year is missing, the claim will be rejected.)
11	Patient Sex	"**Member's sex is required**" (If missing, the claim will be rejected.)
12	Admission Date	"**Admission Date is missing or illegible.**" (Use the bill type table to identify if it is an inpatient (IP) or outpatient (OP) claim; If it is OP, the claim will not reject. If it is IP and a valid date is not billed, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
12	Admission Date	"**Based on the date the claim was received, the admission date is a future date.**" (Use bill type table to identify if it is an IP or an OP claim. If it is OP, the claim will not reject. If it is IP and a future date is billed, reject the claim.)
13	Admission Hour	"**Admission hour is required.**" (Use bill type table to identify if it is an IP or OP claim. If it is OP, the claim will not reject. If it is IP and bill type is anything except 21x and a numeric value is not billed on the claim, the claim will be rejected.)
14	Admission Type	"**Admission type is required.**" (If a numeric value is not present, claim will be rejected.)
15	Source of Referral for Admission or Visit	"**Source of referral for admission or visit is missing.**" (If claim has any bill type except 14x and the field is blank, claim will be rejected.)
16	Discharge Hour	"**Discharge hour is required.**" (Use type if bill table to determine if it is an IP or OP bill type. If IP, the frequency code is either 1 or 4, and this field is blank, claim will be rejected.)
17	Patient Discharge Status	"**Patient discharge status is required.**" (If left blank, claim will be rejected.)
42	Revenue Code	"**Revenue code is missing or illegible.**" (If the revenue code is missing or illegible, the claim will be rejected.)
43	Revenue Description	**"Invalid NDC Code or Unit of Measure"** (In addition to the standard description of the Revenue Code, the NDC Code and Unit of Measure are required in accordance with MDHHS guidelines.)
45	Service Date	"**DOS is missing or illegible.**" (Claim will be rejected if the field is blank on any service line and the claim is submitted with an OP bill type.)
45	Creation Date	"**Creation date is missing or illegible.**" (If the creation date is missing or illegible, the claim will be rejected.)
46	Service Days/Units	"**Days/units are required on line ___." [lines 1-22].** (For each line with a "From" DOS, days/units are required. If a numeric value is not present on each valid service line, the claim will be rejected.)
47	Line Item Charges	"**Line item charge amount is missing on line___." [lines 1-22].** (If a value greater than or equal to zero is not present, the claim will be rejected.)
47	Total Charges	"**Total charge amount is missing.**" (If a value greater than or equal to zero is not present, the claim will be rejected.)
50	Payer	"**Payer name is required.**" (If left blank, the claim will be rejected.)
52	Release of Information	"**Release of information certification indicator is required.**" (If blank, the claim will be rejected.)
53	Assignment of Benefits	"**Assignment of benefits certification indicator is required.**" (If left blank, the claim will be rejected.)
58	Insured's Name	"**Member name is missing or illegible.**" (If first and/or last name are missing or illegible, the claim will be rejected.)

Field #	UB-04 Field/Data Element	"Reject Statement" (Reject Criteria)
59	Patient's Relationship	"**Patient's relationship to insured is required.**" (If blank, the claim will be rejected.)
67A-Q	Other Diagnosis Codes and Present on Admission Indicator	"**Diagnosis codes are missing or illegible.**" (If diagnosis codes are missing or illegible, the claim will be rejected.)
69	Admitting Diagnosis Code	"**Admitting diagnosis code is missing or illegible.**" (If it is an IP claim and field is blank or illegible, the claim will be rejected.)
70	Patient's Reason for Visit	"**Patient's reason for visit is missing.**" (If the claim is OP and field is blank, the claim will be rejected.)
74	Other/Procedure Date	"**Based on the date the claim was received, procedure date is a future date.**" (Use the bill type table to identify if it is an IP or an OP claim; If it is OP, do not reject the claim; If it is IP and a future date is billed, reject the claim.)
74	Other/Procedure Date	"**Procedure date is missing or illegible.**" (Use bill type table to identify if it is an IP or and OP claim. If OP, do not reject the claim. If IP and a valid date is not billed, reject the claim.)
76	Attending Provider Identifiers: Name and NPI	"**Attending physician name and/or number is missing.**" (If attending physician name or NPI number are missing, the claim will be rejected.)
76	Attending Provider Qualifier	"**Attending provider qualifier is missing/ invalid.**" (The claim will be rejected if the "Other provider ID" is present and either: 1.) The 'Qualifier' box is blank or 2.) A qualifier other than 0B/1G/G2 is present.
76	Attending Provider Other ID#	**"Attending Provider NPI is missing."**(The claim will be rejected if qualifier is present and NPI box is blank.)

Claim return letters are sent for claims that cannot be processed

When claims cannot be processed, Blue Cross Complete sends a claim return letter stating the reason. Physicians should follow the instructions in the letter.

Providers should contact Blue Cross Complete Provider Inquiry at 1-888-312-5713 if they have questions about the content of the letter or the instructions contained in the letter.

Providers can check the status of a claim

Providers can check on the status of a claim at any time using NaviNet, at **NaviNet.net** > **Login**.

If the provider has a question about a claim, they should call Blue Cross Complete Provider Inquiry at 1-888-312-5713.

If the claim needs to be reprocessed, the reprocessing will be done during the phone call, if possible. In addition:

- If information on the claim was incorrect, a corrected claim may be submitted.
- If there is an issue with a medical necessity determination, the claim may be appealed.

Review electronic claims that are not clean

The claim payment process does not change for claims filed electronically through the Blue Cross clearinghouse. The 997 Functional Acknowledgment must be reviewed to determine whether the file was accepted for processing or rejected for compliance issues. The 277CA (Claim Status Category Code of A3 or A4) transaction or report should be reviewed to determine whether claims have been returned due to edits in the 837 claims transaction.

When to resubmit a claim

Providers should resubmit a claim for the following reasons:

- The paper claim was returned with a Blue Cross Complete claim return letter describing claim defects that must be corrected.
- The electronic claim was listed in the 277CA transaction or report with Claim Status Category of A3.

Providers shouldn't automatically resubmit claims without first investigating the circumstances.

Guidelines for submitting corrected claims

Providers may submit corrected claims either on paper (using a CMS-1500 for professional claims or a UB-04 for facility claims) or via electronic data interchange.

Note: A corrected claim is one that is resubmitted with a specific change made, such as a different procedure code, diagnosis code or billed amount. Neither the Member ID nor the billing provider can be changed using a corrected claim. Providers must void the original claim and submit a new claim with the correct Member ID and billing provider. A claim shouldn't be submitted as corrected simply to review how the claim was processed during its initial submission.

Corrected claims should be submitted as follows:

- Corrected claims submitted on paper should comply with the following guidelines:
  - On the CMS-1500, Field 22 must contain "7" followed by the original claim ID. On the UB-04, the original claim ID must show in Field 64 and the bill type in Field 4 must end in "7".
  - Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.
  - Original and corrected claims should be sent to:

    Blue Cross Complete Claims
    P.O. Box 7355
    London, KY 40742-7355

  - If you're a provider or facility outside of the State of Michigan and aren't participating with Blue Cross Complete, please submit all claims through your local Blue Cross plan (for Blue Card access).

- Corrected claims submitted electronically should comply with the following guidelines:
  - Use "7" for the replacement of a prior claim, for the type of bill or frequency type in loop 2300, CLM05-03 (837P or 837I). Include the claim number when submitting your claim with the 7.

Note: Use these indicators for claims that were previously processed (approved or denied). Don't use these indicators for claims that contained errors and weren't processed (rejected up front).

- Include the original claim number in segment REF01=F8 and REF02=the original claim number. Don't use dashes or spaces.
- Corrected claims will replace the original claim and must contain all of the dates of service and line items needed to complete the claim for the member.

Corrected claims shouldn't be submitted on paper and electronically at the same time.

Reasons for negative balances

Occasionally, the Remittance Advice will reference a negative balance. A negative balance is created when Blue Cross Complete pays a provider for services and later discovers this payment was incorrect. In most cases, the provider has already processed the Blue Cross Complete payment before the error is caught. When payment is made in error, Blue Cross Complete will take steps to recover the incorrect payment in accordance with terms contained in the provider agreement.

Among the more common reasons for incorrect payments are the following:

- Provider was overpaid for the service rendered due to billing or processing errors.
- Provider was paid in error because of member ineligibility, or the service provided was not authorized.
- It is determined that the member had other primary insurance.

A Negative Balance Report is system generated when the provider has a negative balance on the Remittance Advice.

F. Billing laboratory services

General guidelines for billing laboratory services

Claims for laboratory services are eligible for payment, following MDHHS guidelines.

In addition, it's the responsibility of the physician who orders the laboratory services to know whether the laboratory is contracted with Blue Cross Complete and the laboratory procedure is covered by Medicaid and on the MDHHS fee schedule.

Non-participating laboratories will require a prior authorization before rendering services to Blue Cross Complete members.

Type of service (outpatient/nonpatient)	Preferred providers
Laboratory	**JVHL** provides statewide network and third-party administration for outpatient laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims. **Quest Diagnostics** provides statewide outpatient laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims. **Drugscan** provides statewide outpatient clinical laboratory services. Providers should refer to the ***Blue Cross Complete claims processing*** section of this manual for information on billable in-office laboratory procedures and guidelines for submitting claims.

G. Required reporting of events

Which events must be reported?

Never events and other preventable serious adverse events must be reported on claims for all Blue Cross Complete products.

What are these events?

A never event is a serious, preventable condition that results from health care management and that should never have occurred. A never event is defined as follows:

- A surgical or other invasive procedure performed on the wrong body part or the wrong site.
- A surgical or other invasive procedure performed on the wrong member.
- The wrong surgical or other invasive procedure performed on a member.

A preventable serious adverse event other than a never event is one that meets all of the following criteria:

- It's reasonably preventable through the use of evidence-based guidelines or criteria.
- It's within the control of the facility or the providers practicing within the facility.
- It's the result of an error made in the facility. (That is, the condition wasn't present when the member entered the facility.)
- It results in serious or significant harm.
- It's clearly, unambiguously and precisely identified, reportable and measurable.

Note: In the terminology of government programs, never events and other preventable serious adverse events are known as provider-preventable conditions. Those PPCs that occur in an inpatient hospital setting are called health care-acquired conditions. Those that occur elsewhere are called other provider-preventable conditions. The list of hospital-acquired conditions published by CMS is available at **cms.gov** > Medicare > Hospital-Acquired Conditions (Present on Admission Indicator) > Hospital-Acquired Conditions (on the left navigation bar) > **FY 2013, FY 2014, and FY 2015 Final Hac List (no changes have been made during the past 3 years)**. This document is a list of hospital-acquired conditions with ICD-9 codes.

Information on hospital-acquired conditions with ICD-10 codes is available at cms.gov/HospitalAcqCond/ > **ICD-10-CM/PCS HACs List**.

How to report never events

Providers must comply with the following guidelines when reporting never events:

- **Facility services.** Hospitals are required to submit a no-pay claim (TOB 110) when an erroneous surgery related to a never event is reported. If there are covered services or procedures provided during the same stay as the erroneous surgery, hospitals are required to submit two claims:
  - One claim with covered services or procedures unrelated to the erroneous surgery(s) on a TOB 11X (with the exception of 110)
  - The other claim with the noncovered services or procedures related to the erroneous surgery or surgeries on a TOB 110 (no-pay claim). Within the first five diagnosis codes listed on the claim, the TOB 110 claim should also contain one of the diagnosis codes to indicate the type of preventable serious adverse event: E876.5 (wrong surgery), E876.6 (wrong patient) or E876.7 (wrong body part).

Note: Both the covered and the noncovered claim must have Statement Covers Periods that match.

- **Professional services.** Any claim for an erroneous surgery or procedure rendered by a practitioner should be submitted using the CMS-1500 claim form or an 837P claim transaction. The claim must include the appropriate modifier appended to all lines that relate to the erroneous surgery or procedure using one of the following applicable National Coverage Determination modifiers:
  - PA – surgery wrong body part
  - PB – surgery wrong patient
  - PC – wrong surgery on patient

Note: Physician claims associated with these events should be submitted with a charge of 1 cent.

Never events aren't reimbursed

Blue Cross Complete will not reimburse a hospital or physician in the hospital setting for costs associated with direct actions that result in a never event.

In addition, all services provided in the operating room when an error occurs are considered related and are therefore not covered. No providers who are in the operating room when the preventable serious adverse event occurs and who could bill individually for their services are eligible for payment. All related services provided during the same hospitalization in which the error occurred are noncovered.

Note: Related services do not include performance of the correct procedure.

Policy is administered using APR-DRG Grouper

For DRG-reimbursed hospitals, Blue Cross Complete uses the most current version of the All Patient Refined Diagnosis-Related Groups (APR-DRG) Grouper to administer the policy, incorporating the POA indicator into the DRG assignment.

Note: Blue Cross Complete continues to require authorization for all inpatient services. Authorizations do not change any of the payment guidelines stated here.

H. Other guidelines for submitting claims

Evaluate readmissions to facilities (15-day Readmission)

If a member is readmitted within 15 days of a previous discharge, per MDHHS rules, if the readmission is to the same facility for a related reason; both admissions are considered as one episode for payment purposes. The related admissions must be combined on a single claim. All readmissions that occur within 15 days of the discharge date are subject to Blue Cross Complete review based on the following:

- **Premature discharge** − occurs when a member's condition is not sufficiently stable at discharge, resulting in a readmission within 15 days
- **Planned readmission** − occurs when a member is discharged with a documented plan to readmit for additional services within 15 days without a medical reason for the delay in services
- **Continuation of care** − a readmission due to one of the following:
  - Findings of an acute disease process are documented but not addressed during the first admission.
  - Treatment is initiated but not monitored or evaluated before discharge.
  - There is no follow-up outpatient discharge plan.

Report information on newborns

Providers are required to report the following information on newborns:

- The appropriate priority (type) of admission or visit should be reported. For example, a newborn admission should be reported as type of admission 4 (newborn). When reporting with this type of admission, providers should report one of the following the special point of origin codes:
  - Code 5 (born inside this hospital)
  - Code 6 (born outside of this hospital)
- Birth weight should be reported in grams on all claims with a type of admission 4. Birth weight should be reported as a whole number.
- For cesarean sections or inductions related to gestational age, one of the following should be reported:
  - Condition code 81: C-sections or inductions performed at less than 36 weeks' gestation for medical necessity
  - Condition code 82: Elective C-sections or inductions performed at less than 39 weeks' gestation
  - Condition code 83: C-sections or inductions performed at 39 weeks' gestation or greater

For additional information, providers should refer to **Bulletin MSA-14-34** (effective Oct. 1, 2014) from the Michigan Department of Health and Human Services.

Use National Drug Code to bill physician-administered pharmaceutical products

Providers must report the NDC on all Blue Cross Complete claims for physician-administered pharmaceutical products. The NDC is a unique 11-digit identifier assigned to a drug product by the manufacturer under FDA regulations. Claims will be rejected if the NDC isn't reported or if the NDC reported isn't valid.

The following information is required for each billed pharmaceutical product:

- NDC qualifier N4
- 11-digit NDC
- NDC unit qualifier (GR, ML or UN)
- NDC quantity

When submitting claims, providers should follow these guidelines:

- For professional claims submitted on paper, the required information must be entered into the shaded portion of the fields 24A through 24H on the CMS-1500 form.
- For facility claims submitted on paper, the required information must be entered into Form Locator 43 on the UB-04 form.
- For professional and facility claims submitted electronically, the required information must be reported in the LIN and CTP segment within the 2410 service line loop.

Guidelines for billing pharmacy claims

For pharmacy claims:

- The pharmacy will use the member's Blue Cross Complete de-identified ID number to process claims for regular prescriptions through PerformRx.

Note: The pharmacy can contact PerformRx at 1-888-989-0057 with any questions related to processing and member eligibility.

- The pharmacy will use the Magellan system and the member's state-issued Medicaid Beneficiary ID number to process claims for prescriptions for AIDS and HIV infections and certain psychotropic medications.

Report Medicaid encounter data on all Blue Cross Complete claims

Providers submitting Blue Cross Complete claims must report the following Medicaid encounter data on those claims:

- All diagnosis codes (for every claim)
- All procedure codes (for every claim)
- Both admission and discharge dates (for inpatient services)
- Both revenue and procedure codes (for outpatient hospital services)
- NDCs for all physician-administered pharmaceutical products

Blue Cross Complete reports to MDHHS the encounter data received from providers.

Use EX codes specific to Blue Cross Complete claims

An EX code explains the reason a claim is denied. It's typically a three-character code composed of letters or numbers or both that represents the reason for the denial.

Some EX codes that pertain to Blue Cross Complete claims include:

- Reimbursement for the Vaccines for Children Program
- Consent form for sterilization, certification and verification forms for abortion and acknowledgement form for hysterectomy (For these services, the applicable form(s) must be submitted with the claim.)
- Age exceeds normal range for the procedure

- Mental health provider submitted without provider degree
- Eligibility denials without subscriber liability

How to bill for dual-eligible members

When billing for dual-eligible members (those members with either original Medicare or Medicare Advantage as their primary plan and Blue Cross Complete as their secondary plan), providers should always bill the primary plan.

Additional information about billing dual-eligible members is in the document *What you should know when serving dual-eligible members* at **mibluecrosscomplete.com** > **Dual-eligible Blues members – Provider Q&A**.

For Blue Cross Complete members who are eligible for but not yet enrolled in either original Medicare or a Medicare Advantage product, Blue Cross Complete may not cover the services that Medicare would normally cover or the copayments, coinsurances and deductible that would have been left for the member to pay after Medicare covered the services.

Prospective claims editing policy

Blue Cross Complete claim payment policies, and the resulting edits, are based on guidelines from established industry sources such as the Centers for Medicare and Medicaid Services, the American Medical Association, State regulatory agencies and medical specialty professional societies. In making claim payment determinations, the health plan also uses coding terminology and methodologies that are based on accepted industry standards, including the Healthcare Common Procedure Coding System manual, the Current Procedural Terminology codebook, the International Statistical Classification of Diseases and Related Health Problems manual and the National Uniform Billing Code. Certain circumstances require that medical records be provided to Optum.

Other factors affecting reimbursement may supplement, modify or in some cases, supersede medical/claim payment policy. These factors may include, but aren't limited to legislative or regulatory mandates, a provider's contract, or a member's eligibility to receive covered health care services.

I. Coordination of benefits and subrogation

What is coordination of benefits?

Blue Cross Complete benefits are not provided to the extent that any amounts are paid or payable for expenses to or on behalf of the member under the provisions of any insurance, service benefit or reimbursement plan providing similar direct benefits without regard to fault, including by way of illustration and not limitation: Medicare, Workers' Compensation, Employer's Liability Law or No Fault Automobile Insurance.

In establishing the order of carrier responsibility applicable to health plans covering Blue Cross Complete members, Blue Cross Complete will follow the coordination of benefits guidelines of MDHHS.

All medical bills must first be submitted to the primary insurance carrier. Blue Cross Complete is the payer of last resort.

If a Blue Cross Complete member is injured and requires treatment related to a motor vehicle accident, Blue Cross Complete will require a statement indicating the type of medical coverage carried on the member's automobile insurance.

How to resolve questions about a member's coordination of benefits issues

To resolve a question about a member's coordination of benefits status, providers may do the following:

- Call Blue Cross Complete Provider Inquiry at 1-888-312-5713.
- Write to:

  Blue Cross Complete Claims
  P.O. Box 7355
  London, KY 40742-7355

When to bill for coordination of benefits

Coordination of benefits is a process that defines which health carrier or insurance company pays as primary when a member has more than one source of coverage for health care benefits.

Providers should bill for coordination of benefits only when both of the following circumstances apply:

- The member is covered by more than one health plan and Blue Cross Complete is secondary.
- The primary carrier has been billed and a remittance advice statement has been received showing a balance remaining.

If…	Then…
A claim is sent to Blue Cross Complete and requires coordination of benefits investigation	Payment may be delayed until the primary coverage is determined.
It is determined that Blue Cross Complete is the primary carrier	The claim is processed as usual.
It is determined that Blue Cross Complete is the secondary carrier	The claim will be rejected unless it is submitted with payment information from the primary carrier

As a Michigan Medicaid health plan, Blue Cross Complete is considered the payer of last resort.

Coverage when another-party liability case is in litigation

For members with other-party liability coverage (through Workers' Compensation, etc.), Blue Cross Complete coordinates coverage with the OPL carrier. In instances in which an OPL case is in litigation, reimbursement for medical services is covered by Blue Cross Complete based on the member's certificate. Once the case is settled, Blue Cross Complete works with the OPL carrier, as necessary, to reconcile any reimbursement owed to Blue Cross Complete.

What is subrogation?

If the member has a right of recovery from a person or organization for any benefits or supplies covered under this affiliation agreement (except from a member's health insurance coverage, subject to the coordination of benefits provisions), the member, as a condition of receiving benefits under this contract, will either:

- Pay Blue Cross Complete all sums recovered by suit, settlement or otherwise, to the extent of the benefits provided by Blue Cross Complete and in an amount equal to the Blue Cross Complete payment for those benefits, but not in excess of monetary damages collected; or
- Authorize Blue Cross Complete to be subrogated to the member's rights of recovery, to the extent only of the benefits provided, including the right to bring suit in the member's name at the sole cost and expense of Blue Cross Complete.

In the event a suit instituted by Blue Cross Complete on behalf of the member results in monetary damages awarded in excess of the cash value of actual benefits provided by Blue Cross Complete, Blue Cross Complete shall have the right to recover the costs of suit and the attorney fees out of the excess, to the extent of the cost of such fees. If a member refuses to cooperate with Blue Cross Complete in its filing of a claim for reimbursement, Blue Cross Complete shall have the right (to be exercised at Blue Cross Complete's sole discretion) to request disenrollment of the member and the member's dependents. Such disenrollment shall be subject to the Member Appeals Program.

Blue Cross Complete has the right to payment and recovery

Whenever benefits have been provided by Blue Cross Complete under the contract and the responsibility for payment is with another plan, Blue Cross Complete shall have the right to deny payment or recover from the other plan the reasonable cash value of each service provided by Blue Cross Complete in a total amount necessary to satisfy the intent of this section.

Blue Cross Complete has the right to receive and release necessary information

For the purpose of determining the applicability of and implementing the terms of this section, Blue Cross Complete will be required from time to time to release or to obtain information with respect to a member that it deems to be necessary for such purposes. A member who is claiming benefits under the contract shall furnish to Blue Cross Complete such information as may be necessary to implement this section. This would include notifying Blue Cross Complete if there is any change in other insurance coverage.

In the event that a member refuses to give consent where reasonably required, thereby preventing Blue Cross Complete from pursuing its right under this section, then such refusal shall be considered a material breach of this contract and may constitute, at the discretion of Blue Cross Complete, grounds for member disenrollment from Blue Cross Complete by MDHHS. Such disenrollment shall be subject to the Member Appeals Program.

Section 14: Provider appeals

A. Appealing utilization management decisions

Appeal of utilization management decisions

Appeals are for medical review determinations preservice issues. An appeal is a request for review of an adverse benefit determination. An adverse benefit determination could be the denial or limited authorization of a requested service, including the type or level of service or reduction, suspension, or termination of a previously authorized service, etc. Providers do not have the right to an appeal except on behalf of the affected member. The appeal must be submitted with documentation to support medical necessity or appropriateness.

Appeals will be handled and processed within the timeframes listed below:

Type of appeal	Timeframe to file	Decision
Standard appeal	Sixty (60) calendar days from the date of the denial notification letter*	Within 30 calendar days from Plan receipt of appeal request

Note: There is only one level of appeal.

The appeal should be submitted as follows:

- By writing to:

  Appeals Coordinator
  Blue Cross Complete
  PO Box 41789
  Charleston, SC 29423
- By faxing to 1-855-737-9879

A practitioner, with member consent, may request that Blue Cross Complete furnish the following:

- All documents relevant to the member's appeal as well as copies of the actual benefit provision, guideline, protocol or criteria on which the appeal decision is based
- The names, titles and qualifications of any medical experts whose advice was obtained on behalf of Blue Cross Complete in connection with the appeal, without regard to whether the advice was relied upon in making the appeal decision

B. Appealing claim disputes

Guidelines for disputing a denied claim

A claim dispute is a request for post-service review of claims that have been previously denied, underpaid, or otherwise limited by Blue Cross Complete.

Blue Cross Complete claim denials may be appealed as follows:

- The appeal must be submitted within 365 calendar days of the decision on the claim.
- The documentation that must be submitted with each type of appeal is:

Reason for denial	Documentation required
Timely filing	Supporting documentation must show the claim was filed in a timely manner (Claims must be submitted within 365 calendar days).
Coding edit (CCI edit denial)	Supporting documentation and medical notes or reports must be submitted.
Payment amount	Supporting documentation must be submitted.

*Clinical editing vendors may have different timelines for submitting claims disputes and supersede Blue Cross Complete's timelines.

Blue Cross Complete responds to all claims appeals within 30 business days.

All claim disputes must be submitted to:

Blue Cross Complete Claims Disputes
P.O. Box 7355
London, KY 40742-7355

MDHHS rapid dispute resolution process for hospitals

Note: This section doesn't apply to hospitals that are contracted with Blue Cross Complete**.**

Non-contracted hospitals providing services to Blue Cross Complete members through the MDHHS Hospital Access agreement are eligible to request a rapid dispute resolution process in compliance with the Medicaid Provider Manual, after the hospital has first exhausted its efforts to achieve a resolution through Blue Cross Complete's administrative appeals process. Non-contracted hospitals must submit a request for rapid dispute resolution within 90 days of the plans final determination.

Non-contracted hospitals that haven't signed a Hospital Access agreement, or non-contracted, non-hospital providers don't have access to the rapid dispute resolution process. These providers serving Blue Cross Complete Medicaid members are entitled to initiate a binding arbitration process, after the provider has first exhausted their efforts to achieve a resolution through Blue Cross Complete's administrative appeals process. To initiate binding arbitration, call Blue Cross Complete to obtain a list of arbitrators. Arbitrators are selected by the MDHHS. The decision of the arbitrator is final. If the arbitrator doesn't reverse the decision, the provider is responsible for the arbitrator's charges.

SECTION 15: PAYMENT SYSTEMS

A. Blue Cross Complete uses ECHO Health Inc. for Electronic Funds Transfer

Blue Cross Complete works with ECHO Health Inc. (ECHO®), a leading innovator in electronic payment solutions, to offer electronic payment options. Blue Cross Complete has implemented payment systems to meet providers' requests for more payment options. The payment systems allow providers the ability to receive the following payment options for claims reimbursement:

- ACH/EFT – Automatic deposits direct from the clients' bank to your bank account
- Virtual credit card – virtual debit transaction
- Paper checks by mail

Electronic Funds Transfer

Electronic funds transfers allow you to receive your payments directly in the bank account you designate rather than receiving them by virtual credit card or paper check. When you enroll in EFT, you will automatically receive electronic remittance advices for those payments. All generated ERAs and a detailed explanation of payment for each transaction will also be accessible to download from the ECHO provider portal at providerpayments.com.

Note: Payment will appear on your bank statement from PNC Bank and ECHO as "PNC – ECHO". To sign-up to receive EFT from Blue Cross Complete, visit enrollment.ECHOhealthinc.com/eftadirect/enroll.

- Complete the ERA/EFT enrollment form. Upon submission, paperwork outlining the terms and conditions will be emailed to you directly along with additional instructions for setup.
- ECHO Health supports both NPI and the TIN level enrollment. You will be prompted to select the option that you would like to use during the enrollment process.

Virtual credit card

Virtual Credit Card is a virtual debit transaction in which randomly generated, temporary credit card numbers. Providers will receive either faxed or mailed VCC payment notification containing a number unique to that payment transaction and an instruction page for processing. A detailed explanation of payment or remittance advice will also be included along with the instruction page. **Normal transaction fees apply based on your merchant acquirer relationship.**

Major advantages to VCC are that providers do not have to enroll or fill out multiple forms in order to receive VCC. Personal information, like practice bank account information, will never be requested. Providers will also be able to access their payment the day the VCC is received. Blue Cross Complete providers who are not registered to receive payments electronically will receive VCC payments as their default payment method, instead of paper checks.

Your office must be able to accept credit card payments. Processing VCC payments is similar to accepting and entering patient payments via credit card into your payment system. If you are not currently able to accept credit card payments, please contact the support team at 1-888-492-5579 for other VCC processing options.

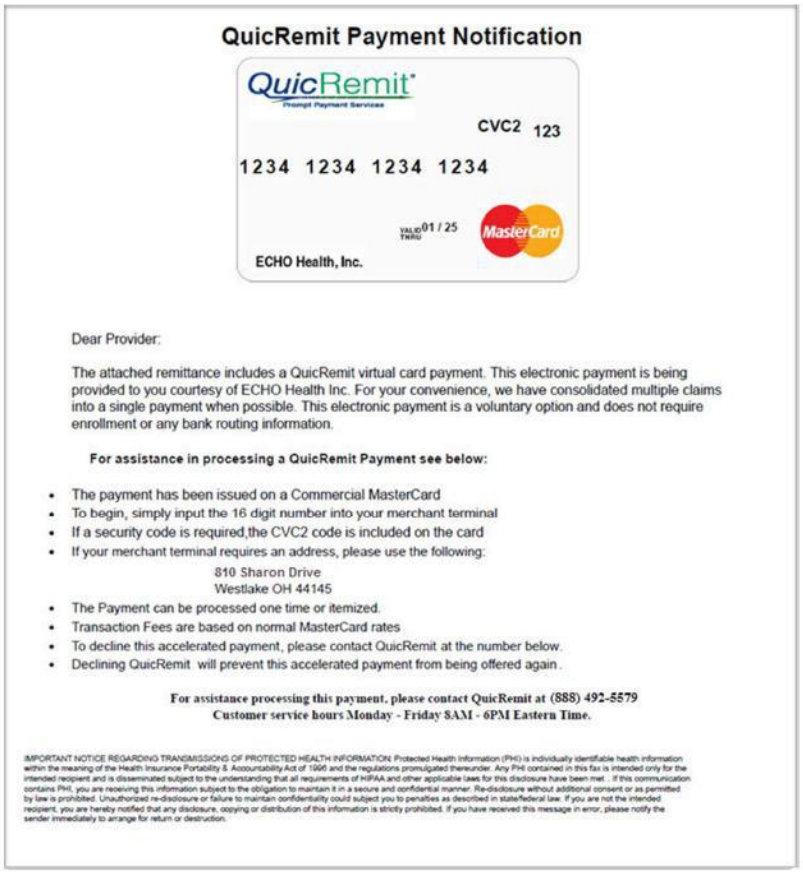
The first attempt to receive a virtual credit card is by fax, if unsuccessful then by mail. When a fax number is available, payments are received 3-7 days earlier than paper checks sent by U.S. Postal Service®.

Virtual credit cards cannot be emailed for security purposes. If the virtual credit card is not processed within 60 days, the transaction will be voided. A request to reissue payment must be made to Blue Cross Complete. Normal credit card transaction fees apply.

Providers who aren't enrolled to receive EFT will automatically receive the VCC. If you don't wish to receive your claim payments through VCC, you can opt out by calling ECHO Health at **1-888-492-5579** to receive a paper check.

Virtual credit card payment notification

Provider offices will receive fax or mail notifications, each containing a virtual credit card with a number unique to that payment transaction. Also included is an instruction page on how to process the payment. See the instruction page example below:



QuicRemit Payment Notification

QuicRemit
Prompt Payment Services

CVC2 123

1234 1234 1234 1234

VALID THRU 01 / 25

MasterCard

ECHO Health, Inc.

Dear Provider:

The attached remittance includes a QuicRemit virtual card payment. This electronic payment is being provided to you courtesy of ECHO Health Inc. For your convenience, we have consolidated multiple claims into a single payment when possible. This electronic payment is a voluntary option and does not require enrollment or any bank routing information.

For assistance in processing a QuicRemit Payment see below:

- The payment has been issued on a Commercial MasterCard
- To begin, simply input the 16 digit number into your merchant terminal
- If a security code is required,the CVC2 code is included on the card
- If your merchant terminal requires an address, please use the following:
  810 Sharon Drive
  Westlake OH 44145
- The Payment can be processed one time or itemized.
- Transaction Fees are based on normal MasterCard rates
- To decline this accelerated payment, please contact QuicRemit at the number below.
- Declining QuicRemit will prevent this accelerated payment from being offered again.

For assistance processing this payment, please contact QuicRemit at (888) 492-5579
Customer service hours Monday - Friday 8AM - 6PM Eastern Time.

IMPORTANT NOTICE REGARDING TRANSMISSIONS OF PROTECTED HEALTH INFORMATION: Protected Health Information (PHI) is individually identifiable health information within the meaning of the Health Insurance Portability & Accountability Act of 1996 and the regulations promulgated thereunder. Any PHI contained in this fax is intended only for the intended recipient and is disseminated subject to the understanding that all requirements of HIPAA and other applicable laws for this disclosure have been met. If this communication contains PHI, you are receiving this information subject to the obligation to maintain it in a secure and confidential manner. Re-disclosure without additional consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties as described in state/federal law. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this message in error, please notify the sender immediately to arrange for return or destruction.

B. Receive electronic remittance advice statements

Electronic Remittance Advices, often referred to as an 835 file are also available through ECHO Health. To receive ERAs from Blue Cross Complete, it is important to check with your practice management/hospital information system vendor to see if the system includes both the Blue Cross Complete payer ID: **32002** and the ECHO Health Payer ID 58379.

Contact your practice management/hospital information system for instructions on how to receive ERAs from Blue Cross Complete under Payer ID **32002** and the ECHO Payer ID **58379**. If your practice management/hospital information system is already set up and can accept ERAs from Blue Cross Complete then it is important to check that the system includes both Blue Cross Complete under Payer ID and ECHO Health Payer ID for ERAs.

Note: Effective July 1, 2025, Blue Cross Complete will no longer utilizes **payer ID 32002** for electronic claims submissions via Availity. To help ensure uninterrupted claims processing, providers should submit electronic claims for Availity using payer IDs **00710** for Institutional/Hospital or **00210** for Professional/Medical.

If you are not receiving any payer ERAs, please contact your current practice management/hospital information system vendor to inquire if your software has the ability to process ERAs. Your software vendor is then responsible for contacting ECHO to enroll you for ERAs under the Blue Cross Complete payer ID and ECHO Health Payer ID. To receive ERAs from ECHO, visit echohealthinc.com/provider/.

If your software does not support ERAs or you continue to reconcile manually, and you would like to start receiving ERAs only, please contact the ECHO Health Enrollment team at **1-888-834-3511**.

Providers who have questions about EFT, VCC or ERAs should contact ECHO Health at **1-888-834-3511** or their Blue Cross Complete provider account executive.

Section 16: Health Care Fraud, Waste and Abuse

A. Special Investigations Unit

Blue Cross Complete of Michigan is a member of the AmeriHealth Caritas Family of Companies. AmeriHealth Caritas has an established enterprise-wide Program Integrity department with a proven record in preventing, detecting, investigating, and mitigating fraud, waste, and abuse. Our existing program has been developed in accordance with 42 CFR § 438.608, 42 CFR Part 455, the governing contracts between Blue Cross Complete and the State of Michigan, and applicable federal and state laws.

The Program Integrity department utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Blue Cross Complete or, on behalf of Blue Cross Complete, regarding payment or recovery of potential overpayments. You may be asked to provide supporting documentation including the medical record or itemized bill to support the review of the claim. In addition, you may be informed that your claim submission patterns vary from industry standards when reviewed and compared to your peer's submission of similar claims; if this were to occur you would be notified and additional action may be required on your behalf. Should you have any questions regarding the communication received relating to these requests, please use the contact information provided in the communication to expedite a response to your question or concerns. Prior authorization is not a guarantee of payment for the service authorized, as all paid claims are subject to audit. Blue Cross Complete reserves the right to adjust any payment made following a review of the medical record or other documentation and/or determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between when the authorization was issued and the service was provided.

The Program Integrity department has cross-functional teams that support its activities to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with the requirements as set forth in 42 C.F.R. Part 438, Subpart H (Certifications and Program Integrity) and 42 C.F.R. § 457.950(a)(2).

The Special Investigations Unit is housed within the Program Integrity department. The SIU team is responsible for detecting fraud, waste, and abuse throughout the claims payment processes for Blue Cross Complete. The SIU staff includes experienced investigators and analysts, including certified professional coders, certified fraud examiners, and accredited health care fraud investigators.

Among other things, the SIU conducts the following activities:

- Reviews and investigates all allegations of fraud, waste and abuse.
- Takes corrective actions for any supported allegations after thorough investigation, including recovering overpayments that result from fraud, waste, or abuse.
- Reports confirmed misconduct to the appropriate parties and agencies.
- Ongoing evaluation of claims data (both prospectively and retrospectively) to trend claims behavior and detect aberrant patterns in provider billing, prior authorizations, and member utilization patterns.

B. Definitions of Fraud, Waste and Abuse

Fraud – As defined within 42 C.F.R. § 455.2, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal and state law.

Waste – The overutilization of services or other practices that result in unnecessary costs. Waste is generally not considered caused by criminally negligent actions, but rather misuse of resources.

Abuse – As defined within 42 C.F.R. § 455.2, abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary costs to the Medicaid program.

Fraud & Abuse – Summary of Relevant Laws and Examples

Blue Cross Complete of Michigan is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including the Medicaid Fraud Control Unit of the Michigan Department of Attorney General , the Federal Bureau of Investigation, the Drug Enforcement Administration, the federal Office of Inspector General of the U.S. Department of Health and Human Services, as well as the Michigan Department of Health and Human Services Office of Inspector General. As part of Blue Cross Complete of Michigan's responsibilities, the Program Integrity department, and the SIU in particular, is responsible for identifying and recovering overpayments. The SIU performs several operational activities to detect and prevent fraudulent and abusive activities.

The Federal False Claims Act

The False Claims Act is a federal law that prohibits knowingly presenting, or causing to be presented, a false or fraudulent claim to the federal government or its contactors, including state Medicaid agencies, for payment or approval. The FCA also prohibits knowingly making or using, or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved. Penalties for violating the FCA include damages in the amount of up to three times the amount of the false claim plus civil penalties of $10,957 to $21,915 per false claim.

The FCA contains a whistleblower provision to encourage individuals to report misconduct involving false claims. The whistleblower provision allows any person with actual knowledge of allegedly false claims submitted to the government to file a lawsuit on behalf of the U.S. Government. The whistleblower provisions of the FCA protects individuals from retaliation that results from filing an action under the FCA, investigating a false claim, or providing testimony for or assistance in a federal FCA action.

C. The Federal Fraud Enforcement and Recovery Act

The Fraud Enforcement and Recovery Act of 2009 was passed by Congress to enhance the criminal enforcement of federal fraud laws, including the FCA. Penalties for violations of FERA are comparable to penalties for violation of the FCA.
Among other things, FERA:

- Expands potential liability under the FCA for government contractors like Blue Cross Complete of Michigan.
- Expands the definition of a false or fraudulent claim to include claims presented not only to the government itself, but also to a government contractor like Blue Cross Complete of Michigan.
- Expands the definition of a false record to include any record that is material to a false or fraudulent claim.
- Expands whistleblower protections to include contractors and agents who claim they were retaliated against for reporting potential fraud violations.

The Michigan False Claim Act imposes liability on persons who knowingly submit false or fraudulent claims to Michigan's Medicaid Program. The Michigan FCA authorizes suits to be filed by whistleblowers and provides protections from retaliation by the whistleblowers' employer. In order for a State to enact its own state-specific FCA legislation, the state's proposed legislation must meet the standards and guidelines of the Deficit Reduction Act. The U.S. Department of Health and Human Services Office of Inspector General maintains the Deficit Reduction Act standards. Each state's FCS legislation must be reviewed by the OIG. Enacting FCA legislation helps a state reduce the number of false and fraudulent claims submitted to the State's Medicare and Medicaid programs. The increase in the share of the amount recovered also increases the state's funding.

Examples of fraudulent/abusive activities:

- Billing for services not rendered or not medically necessary
- Submitting false information to obtain authorization to furnish services or items to Medicaid recipients
- Prescribing items or referring services which are not medically necessary
- Misrepresenting the services rendered
- Submitting a claim for provider services on behalf of an individual that is unlicensed, or has been excluded from participation in the Medicare and Medicaid programs
- Retaining Medicaid funds that were improperly paid
- Billing Medicaid recipients for covered services
- Failing to perform services required under a capitated contractual arrangement
- Misrepresenting dates and times of service
- Misusing Electronic Medical Records, such as by cloning and copying so records are identical, not unique, and/or specific as required
- Failing to have supporting documentation for billed services

D. Reporting and Preventing Fraud, Waste and Abuse

If you, or any entity with which you contract to provide health care services on behalf of Blue Cross Complete of Michigan members, become concerned about or identifies potential fraud, waste or abuse, please contact Blue Cross Complete Special Investigation Unit by:

- **Phone:** 1-855-232-7640.
- **Fax:** 1-215-937-5303
- **Email:** FraudTip@mibluecrosscomplete.com

- **Mailing a written statement to:**
  Blue Cross Complete Special Investigations Unit
  P.O. Box 018
  Essington, PA 19029

Below are examples of information that will assist Blue Cross Complete with an investigation:

- Contact Information (e.g., name of individual making the allegation, address, telephone number)
- Description of the alleged fraudulent or abuse activities
- Timeframe of the allegation(s)
- Name and identification number of the suspected individual
- Source of the complaint, including the type of item or service involved in the allegation
- Approximate dollars involved, if known
- Place of service

All information that is referred to the Blue Cross Complete SIU will be given in cooperation with MDHHS and the Michigan Office of the Attorney General, as required by the Medicaid contract and regulations. The Blue Cross Complete Antifraud Unit supports the efforts of local and state authorities in the prosecution of reported cases of fraud.

Reports of suspected fraud regarding Blue Cross Complete may also be made directly to MDHHS Office of Inspector General in one of the following ways:

- **Website:** Office of Inspector General
- **Online at:** michigan.gov/fraud
- **Phone:** 1-855-643-7283
- **By writing to**:
  Office of Inspector General
  P.O. Box 30062
  Lansing, MI 48909

Information may be left anonymously.

E. What to expect as a result of SIU activities

The SIU must review all complaints that are received and, as a result, you may be asked to provide certain information in order for the SIU to thoroughly look at all complaints. The SIU utilizes internal and external resources to ensure the accuracy of claims payments and the prevention of claims payments associated with fraud, waste, and abuse. As a result of these claims accuracy efforts, you may receive letters from Blue Cross Complete of Michigan regarding recovery of potential overpayments and/or requesting medical records for review. Should you have any questions regarding a letter received, please use the contact information provided in the letter to expedite a response to your question or concerns.

- You may also be contacted by the SIU Intake Unit to verify a complaint you filed.
- You may be contacted by an investigator in regards to a complaint they are investigating which may or may not concern you.

- As a provider you may be requested to provide medical records for review. This request will be sent via a letter explaining the process to submit the records All Medicaid providers rendering services to BCC members are required to provide the records for review.

  Provider agrees to cooperate with Blue Cross Complete of Michigan in maintaining and providing to Blue Cross Complete of Michigan or the Department, at no cost to them, medical records, financial data, administrative materials and other records related to services to members as may be reasonably requested by Blue Cross Complete of Michigan or the Department.

- You may be contacted by an investigator in regard to a prepayment review. If a prepayment review is activated or initiated, the provider will receive communications on where to send records and the provider must ensure that medical records are submitted with each claim during the review process to the address noted in the letter.

After an investigation is completed, there are a number of things that may occur such as a determination that the complaint was unfounded or a referral to:

1. Michigan Department of Health and Human Services Office of Inspector General,
2. Medicaid Fraud Control Unit or
3. The federal Office of Inspector General for further investigation

You may receive an overpayment letter that outlines what was found and if monies are owed. You could also receive and education letter that outlines proper procedures that are to be followed for future reference. You could be placed on prepayment review. Should you, as the provider, dispute the findings of the medical record review or prepayment review, SIU will conduct an independent audit on 100% of the provider's dispute. This review may result in a revision of the original overpayment amount. Disputes should be filed with the SIU within 30 days of the date of the notification, and in adherence of Blue Cross Complete of Michigan requirements:

Blue Cross Complete reserves the right to grant an additional 15-day extension at the discretion of the reviewer if the provider gives a valid reason why he or she was not able to submit a timely dispute. Upon completion of its review of the provider's submitted dispute materials, Blue Cross Complete will make every effort to return the dispute determination within 30 days of the provider's dispute.

If Blue Cross Complete does not hear from the provider within 30 days from either the initial written overpayment notification or the dispute determination notification, the final overpayment amount will be offset from future claims payments. In cases where recovery through offsetting will take longer than six months, Blue Cross Complete reserves the right to seek additional legal recourse such as referral to a collection service. If the provider remains unsatisfied upon receipt of the rebuttal review determination notification, the contracted provider should follow the dispute processes outlined within the Provider Agreement. .

MDHHS-OIG will perform post payment evaluations of Blue Cross Complete's network providers for any potential fraud, waste and abuse and to recover overpayments made by Blue Cross Complete when the post payment evaluation was initiated and performed by MDHHS-OIG.

Providers must adhere to the Medicaid Provider Manual. Providers must agree that MDHHS-OIG has the authority to conduct post payment evaluations of their claims paid by Blue Cross Complete. Providers must agree to follow the appeals process as outlined in chapters 4 and 6 of the Administrative Procedures Act of 1969; MCL 24.271 to 24.287 and MCL 24.301 to 24.306 for post payment evaluations conducted by MDHHS-OIG.

Note: The recovery of overpayments by MDHHS-OIG are not subject to Blue Cross Complete's provider appeal process. Blue Cross Complete is required to recover overpayments determined by MDHHS-OIG post payment evaluations.

Submitting a Refund

Blue Cross Complete of Michigan encourages providers to conduct regular self-audits to ensure receipt of accurate payment(s) from Blue Cross Complete. Medicaid program funds must be returned when identified as improperly paid or overpaid. If a provider identifies improper payment or overpayment of claims from Blue Cross Complete, the improperly paid or overpaid funds must be returned to Blue Cross Complete within 60 days from the date of discovery of the overpayment. Providers may return improper or overpaid funds to Blue Cross Complete by:

1. Completing page one of the *Provider Claim Refund Form* at mibluecrosscomplete.com.
2. Using page two of the form or attaching your spreadsheet with the pertinent fields from the form, as needed, to list multiple claims connected to the return payment.
3. Submitting the completed form, attachments and refund check by mail to the claims processing department:

   Blue Cross Complete of Michigan
   Attn: Provider Refunds
   P.O. Box 7355
   London, KY 40742

Self-Audit Request

The Special Investigations Unit may request providers to conduct a self-audit. Any overpayment assessed from the SIU's self-audits request should be returned to SIU using the address below and must include a copy of the self-audit request letter.

Blue Cross Complete of Michigan
Attn: (Name of Investigator)
P.O. Box 7317
London, KY 40742

If a provider is unsure that an overpayment has occurred, contact Blue Cross Complete Provider Inquiry at 1-888-312-5713.

Section 17: Program Integrity

Blue Cross Complete is obligated to ensure the effective use and management of public resources in the delivery of services to its members. Blue Cross Complete does this in part through its Program Integrity department whose programs are aimed at the accuracy of claims payments and to the detection and prevention of fraud, waste, or abuse. In connection with these programs, you may receive written or electronic communications from or on behalf of Blue Cross Complete, regarding payments or recovery of potential overpayments. The Program Integrity department utilizes both internal and external resources, including third party vendors, to help ensure claims are paid accurately and in accordance with your provider contract. Examples of these Program Integrity initiatives include:

A. Prospective (Pre-claims payment)

- **Claims editing** – policy edits (based on established industry guidelines/standards such as Centers for Medicare and Medicaid Services, the American Medical Association, state regulatory agencies or Blue Cross Complete medical/claim payment policy) are applied to prepaid claims.
- **Medical Record/Itemized bill review** – a medical record or itemized bill may be requested in some instances prior to claims payment to substantiate the accuracy of the claim.

  Note: Claims requiring itemized bills or medical records will be denied if the supporting documentation is not received within the requested timeframe.
- **Coordination of benefits** - Process to verify third party liability to ensure that Blue Cross Complete is only paying claims for members where Blue Cross Complete is responsible, i.e. where there is no other health insurance coverage.
- Within the clearinghouse environment, a review of claim submission patterns will be performed to identify variances from industry standards and peer group norms. If such variations are identified, you may be requested to take additional actions, such as verifying the accuracy of your claim submissions, prior to the claim advancing to claims processing.

B. Retrospective (Post-claims payment)

- **Third party liability/Coordination of benefits/Subrogation** – As a Medicaid plan, Blue Cross Complete is the payor of last resort. The effect of this rule is if Blue Cross Complete determines a member has other health insurance coverage, payments made by Blue Cross Complete may be recovered.

  Also see the **Claims** section of this manual for further description of TPL/COB/Subrogation.
- **Data mining**– Using paid claims data, Blue Cross Complete identifies trends and patterns to determine invalid claim payments or claim overpayments for recovery.
- **Medical records review/itemized bill review** – a Medical record or itemized bill may be requested to validate the accuracy of a claim submitted as it relates to the itemized bill. Validation of procedures, diagnosis or diagnosis-related group (“DRG”) billed by the provider. Other medical record reviews include, but are not limited to, place of service validation, re-admission review and pharmacy utilization review.

  Note: if medical records are not received within the requested timeframe, Blue Cross Complete will recoup funds from the provider. Failure to provide medical records creates a presumption that the claim as submitted is not supported by the records.

C. Credit Balance Issues

- Credit balance review service conducted in-house at the provider's facility to assist with the identification and resolution of credit balances at the request of the provider.
- **Overpayment collections** – Credit balances that have not been resolved in a timely manner will be subject to offset from future claims payments and/or referred to an external collections vendor to pursue recovery.

If you have any questions regarding the programs or the written communications about these programs and actions that you need to take, please refer to the contact information provided in each written communication to expedite a response to your question or concerns.

Prior authorization is not a guarantee of payment for the service authorized. Blue Cross Complete reserves the right to adjust any payment made following a review of the medical records or other documentation or following a determination of the medical necessity of the services provided. Additionally, payment may also be adjusted if the member's eligibility changes between the time authorization was issued and the time the service was provided**.**