February 2013

Articles in this issue…

Electronic *Record* subscription.... 1
Ambulatory infusion centers........ 2
Dialysis, ESRD billing.................. 2
Reporting guidelines for additional diagnoses 3
Urgent care centers..................... 3
HIT participant agreement........... 3
Behavioral health criteria............. 4
Healthy Blue Outcomes[SM] reminders.................................. 4
Imaging management program ... 5
Blues highlight medical, benefit policy changes 6
PPO program............................ 13
HEDIS medical record reviews.. 14
Medicare Advantage therapy caps 14
Include rendering practitioner NPI on claims 15
Report numeric amounts in charge field.............................. 15
2012 Medicare Advantage claims reminder....................... 15

Electronic *Record* subscription gives fast, easy access to Blues news

Subscribers to the electronic *Record* have quicker, easier access to Blues news that they need.

When you subscribe, you'll receive the newsletter as an automatic email each month earlier than your printed edition reaches you. Blue Cross Blue Shield of Michigan typically sends the electronic *Record* on the last business day of the month. That means current subscribers should have received this February issue on Jan. 31.

The electronic *Record* is also available on **bcbsm.com** and web-DENIS every month, along with an archive of past issues and the current *Record* index. To find the archive and index:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters and Resources.*
- Click on *Newsletters Past Issues and Indexes*.

Subscribe to the electronic *Record* at **bcbsm.com**:

- Click on *I am a Provider*.
- Click on *Provider Publications* at the left side of your screen.
- Click on the *Subscribe* link.

Once you begin receiving the electronic *Record*, you may remove your name from the mailing list for the printed version by faxing a request on your letterhead to our database administrator at 1-800-553-1369 or writing to:

The Record
Corporate Communications – Mail Code 0245
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

Coming soon: BCBSM to contract with ambulatory infusion centers

Blue Cross Blue Shield of Michigan will contract with qualified ambulatory infusion centers under a newly modified Infusion Therapy Provider Class Plan this year.

AICs administer infusion therapy and select injections to patients in freestanding outpatient facilities. AICs will provide an additional location option for patients receiving infusion therapy.

Applications for enrollment are expected to be available in May 2013 for an Aug. 1, 2013, effective date.

The addition of ambulatory infusion centers means that:

- AICs will be designated as a unique provider type.
- We will formally contract with AICs.
- AICs will be identified in the provider directory on **bcbsm.com** and the Blue Cross and Blue Shield Association website.
- AICs will be reimbursed for the administration of infusion therapy and select injections as well as related medications.
  - AICs will be reimbursed for medications at the same rate as home infusion therapy providers.
  - Payment for administration of the drugs will be the same as under the physician office infusion therapy benefit.
- Participation for AICs is on a formal basis only, which means there is no "per-claim" participation. BCBSM will not pay for infusion therapy services provided by nonparticipating AICs.
- All participating AICs will be considered to be in-network for PPO members, and out-of-network sanctions will be waived.

Home infusion therapy providers that have infusion suites will need to register as AICs to be reimbursed for services provided in the infusion suites. You may continue to provide home infusion therapy under your current HIT agreement.

Key eligibility requirements

Ambulatory infusion centers must meet BCBSM's quality standards and be fully accredited in infusion therapy by a national accreditation organization such as The Joint Commission, The Accreditation Commission for Health Care or the Community Health Accreditation Program. AIC staff must be trained in infusion therapy and include, at a minimum, a registered pharmacist, a registered nurse and a medical director, all licensed by the state of Michigan.

If you are interested in joining this network, enrollment materials will be available electronically on **bcbsm.com** in May. Look for more information in future issues of *The Record.*

Billing for dialysis services, ESRD clarified

Under current BCBSM policy, condition codes are required for all revenue codes when billing for dialysis services. Beginning April 1, 2013, claims for dialysis services billed without a condition code, with the exception of revenue code 0880, will be returned for correction.

This applies to both hospitals and freestanding dialysis centers.

The following chart reflects valid revenue code and condition code combinations.

Revenue codes and nomenclature		Condition codes				
		71	72	73	74	76
		Full care in unit	Self-care in unit	Self-care training	Home	Back-up in-facility dialysis
0821	Hemodialysis/composite or other rate	X	X	X	X	X
0831	Peritoneal dialysis/ composite or other rate	X				
0841	CAPD/composite or other rate			X	X	
0851	CCPD/composite or other rate			X	X	
0880	Miscellaneous dialysis - general					
0881	Ultrafiltration	X				

For complete billing instructions, please check your provider manual on web-DENIS.

Guidelines for reporting additional diagnoses

Health conditions that affect a member's inpatient hospital care but that are in addition to the reason for admission should be reported as "additional diagnoses."

Follow these guidelines when submitting codes on an inpatient claim for "additional diagnoses":

- According to the Uniform Hospital Discharge Data Set, "additional diagnoses" include additional conditions that affect patient care in terms of requiring:
  - Clinical evaluation
  - Therapeutic treatment
  - Diagnostic procedures
  - Extended hospital stays
  - Increased nursing care and monitoring
- The UHDDS also defines "additional diagnoses" as any conditions that coexist at the time of the patient's admission, develop subsequently or affect treatment received and increase the length of stay.
- A diagnosis that is related to a previous episode and has no effect on the current hospital stay is excluded.
- Report additional diagnoses for inpatients in acute care, short-term or long-term care facilities or a psychiatric hospital setting.
- Conditions that are treated in outpatient settings, such as acute care, short-term or long-term care, psychiatric hospitals, home health agencies, rehab facilities and nursing homes, are now categorized under "additional diagnoses."

Our audit teams use *BCBSM Documentation Guidelines for Physician and Other Professional Providers* and several nationally-accepted coding guidelines to determine the accuracy and validity of codes submitted on inpatient hospital claims. These guidelines include:

- AHA Coding Clinic
- Uniform Hospital Discharge Data Set
- ICD-9-CM Official Guidelines for Coding and Reporting

Billing and participation for hospital urgent care centers summarized

In the December 2012 issue of *The Record*, we explained that urgent care evaluation and management services (*99201-*99205, *99211-*99215, *99381-*99387 and *99391-*99397) provided in the hospital outpatient setting must be reported on a professional claim effective April 1, 2013. This billing change mirrors how BCBSM pays our participating freestanding urgent care centers today for these services.

We encourage hospital outpatient urgent care departments to join the BCBSM Urgent Care Center Network, if they haven't done so already.

By participating in the network, your location is automatically listed in BCBSM's urgent care center provider directory. This makes it easier for members to find you when they need an urgent care center.

To enroll in the urgent care center network, go to the *Provider* section of **bcbsm.com** and click on *Sign up today*.

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Home infusion therapy participation agreement updated

The BCBSM Home Infusion Therapy Participation Agreement has been updated effective May 1, 2013, to the newer participation agreement format. The revised agreement will be available for your review Feb. 1 by clicking on the link found in the participation chapter of the HIT provider manual on web-DENIS.

Updates to the participation agreement include (but are not limited to) consistent definitions, standard hold harmless provisions, updated Blue Cross and Blue Shield Association disclosure language and moving the detailed description of the appeals process to the provider manual.

FACILITY, PROFESSIONAL

Behavioral health medical necessity criteria updates available next month on web-DENIS

The Magellan Behavioral Health Medical Necessity Criteria have been updated for 2013 and will be available on web-DENIS March 1.

The document contains medical necessity criteria for psychiatric and substance abuse treatment, including criteria for medical detoxification, which is considered a behavioral health benefit. However, medical detoxification is considered a medical benefit for Federal Employee Program members.

The new criteria will be effective March 1, 2013.

Please note that the 2013 criteria should be used in tandem with the 2013 Behavioral Health Criteria Application Guidelines.

Health care providers may print or copy the 2013 guides directly from web-DENIS. To access the document, go to web-DENIS and follow these steps:

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters & Resources*.
- Click on *Clinical Criteria & Resources*.
- Click on *2013 updated Magellan Behavioral Health Medical Necessity Criteria* under *Resources*.

If you have any questions, call Behavioral Health Services at 313-448-7745.

PROFESSIONAL

Important reminders for Healthy Blue Outcomes℠ patients

Blue Cross Blue Shield of Michigan's outcomes-based PPO, Healthy Blue Outcomes, ties a financial incentive to positive behavioral outcomes. You may have patients with this coverage, so below are some helpful reminders about the Healthy Blue Outcomes program:

- Under Healthy Blue Outcomes, a patient must complete the online health assessment and meet with a physician to complete the *Qualification Form* within 90 calendar days of his or her benefit effective date.

  Note: BCBSM and Blue Care Network use different qualification forms. BCBSM does not reimburse health care providers for completion of the *Qualification Form*.
- If a member has a medical condition that makes it unreasonably difficult or inadvisable to meet the health requirements, his or her physician may request a medical waiver.

The *Medical Waiver* request form is separate from the *Qualification Form* and can be downloaded from web-DENIS or by following these instructions:

- Visit **bcbsm.com** and click on the *Providers* at the top of the page.
- Click on *Help*.
- Click on *FAQs*.
- Click on *How to participate in Healthy Blue Outcomes*.
- Click on *medical waiver (PDF)*.

You can complete the *Medical Waiver* request form along with the *Qualification Form* during the member's preventive care medical exam. Be sure to sign the *Medical Waiver* request form, and instruct your patient to fax it to the number listed on the form within 120 days of his or her benefit effective date. When you complete the waiver, make sure to complete the member health improvement plan with your patient, too.

The *Medical Waiver* request form can be used to ask for a waiver of all requirements for members who are in hospice. The member's authorized representative can call the Engagement Center to ask for an override, too.

- Please remember to use in-network independent laboratories or other facilities for analysis of patient lab work.
- As of Oct. 1, 2011, you must administer a cotinine test for Healthy Blue Outcomes members to determine whether they use tobacco.

One cotinine test per member each calendar year is covered 100 percent when performed by an in-network physician and billed with the appropriate procedure codes below. Acceptable testing methods include either a urine test or a serum test.

HEALTHY BLUE OUTCOMES continued on Page 5

HEALTHY BLUE OUTCOMES **continued from Page 4**

Note: If a member is using a smoking cessation method, he or she should inform you during the initial office visit. The test value doesn't need to be recorded on the *Qualification Form*.

Here are the appropriate procedure and diagnosis codes to use when submitting claims to BCBSM for this test:

Procedure codes

- *80101: Payable with any of the diagnosis codes below.
- *83887: There are no diagnosis restrictions for this code.
- G0434: Payable with any of the diagnosis codes below.

Diagnosis codes

- 989.84: Toxic effect of tobacco (non-tobacco users)
- V15.82: Personal history of tobacco use, presenting hazards to health (tobacco users)
- 305.1: Nondependent tobacco use disorder
- V70.3: Other medical examination for administrative purposes

If you have any questions, contact your provider consultant for more information.

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Anthem BCBS, BlueAdvantage Administrators of Arkansas roll out new imaging management program for their members in Michigan

A new imaging management program for many Anthem Blue Cross Blue Shield and BlueAdvantage Administrators of Arkansas members who live in Michigan went into effect Jan. 1, 2013.

It requires designated Anthem BCBS and BlueAdvantage members to obtain authorization for elective, outpatient high-tech radiology services. These include CT scans, MRIs and nuclear cardiology tests, as well as PET and echocardiography exams.

Health care providers can determine if a member participates with the program by checking the back of their identification card for a high-tech imaging precertification phone number. You can request authorization by calling the number. (Members may also initiate the request.)

Note: The only BlueAdvantage members included in the program are Tyson and Walmart employees.

The program, managed by AIM Specialty Health^{SM}, includes two main components:

- **Authorization needed**
  Designated members must obtain authorization through their health care providers for elective, outpatient high-tech radiology services managed by AIM Specialty Health.

  Authorization is not needed for imaging performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery (hospitals and freestanding surgery centers), urgent care centers or 23-hour observations.
- **Imaging facility options**
  Members who are referred to an imaging provider may receive a call from AIM if there is a lower cost, high-quality provider available within 30 miles. Members can choose either to follow their doctor's referral or go to the AIM-referred facility.

  This outreach effort will not include pediatric or cancer patients.

If authorization is not obtained, a member may be responsible for the full cost of the imaging service. Participating health care providers should continue to bill for covered services following established procedures.

If you have any questions or need more information, contact your provider consultant or call the imaging precertification number on the back of the member's ID card.

Blues highlight medical, benefit policy changes

You'll find the latest information about procedure codes and Blue Cross Blue Shield of Michigan billing guidelines in the following chart.

This billing chart is organized numerically by procedure code. Newly approved procedures will appear under the *New Payable Procedures* heading. Procedures for which we have changed a billing guideline or added a new payable group will appear under *Updates to Payable Procedures*. Procedures for which we are clarifying our guidelines will appear under *Policy Clarifications*. New procedures that are not covered will appear under *Experimental Procedures.*

You will also see that descriptions for the codes are no longer included. This is a result of recent negotiations with the AMA on use of the codes.

We will publish information about new BCBS groups or changes to group benefits under the *Group Benefit Changes* heading.

For more detailed descriptions of the BCBSM policies for these procedures, please check under the *Medical/ Payment Policy* tab in Explainer on web-DENIS. To access this online information:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications & Resources*.
- Click on *Benefit Policy for a Code*.
- Click on *Topic*.
- Under *Topic Criteria*, click the drop-down arrow next to *Choose Identifier Type* and then click on *HCPCS Code*.
- Enter the procedure code.
- Click on *Finish*.
- Click on *Search*.

Code*	**BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines**
UPDATES TO PAYABLE PROCEDURES	
0099T, 65710, 65760, 65765, 65767, 65770-65772, 65775, 66999, L8699, S0800, S0810, S0812	**Basic Benefit and Medical Policy** Inclusionary and exclusionary guideline updates for refractive keratoplasties and implantation of intrastromal corneal ring segments are effective March 1, 2013. **Inclusionary Guidelines** • Epikeratophakia for the treatment of aphakia • The patient must have deteriorating vision not correctable with eyeglasses or contact lenses, or must be unable to wear contact lenses. • Implantation of intrastromal corneal ring segments (Intacs®) for the treatment of keratoconus is appropriate when all of the following criteria are met: – The patient has experienced a progressive deterioration in his or her vision, such that he or she can no longer achieve adequate functional vision with contact lenses or spectacles. – Corneal transplantation is the only alternative to improve the patient's functional vision. – The patient has a clear central cornea with a corneal thickness of 450 microns or greater at the proposed incision site. **Exclusionary Guidelines** • Keratophakia • Refractive keratoplasty procedures that are cosmetic in nature **Continued on next page**

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BENEFIT POLICY continued on Page 7

BENEFIT POLICY continued from Page 6

UPDATES TO PAYABLE PROCEDURES	
0099T, 65710, 65760, 65765, 65767, 65770-65772, 65775, 66999, L8699, S0800, S0810, S0812 ***Continued***	• Implantation of intrastromal corneal ring segments (Intacs®) for the treatment of myopia
33140, 33141, 33999	**Basic Benefit and Medical Policy** Inclusionary and exclusionary guideline updates for transmyocardial revascularization are effective March 1, 2013. **Inclusionary Guidelines** • For open transmyocardial laser revascularization, patients with Class III or IV angina who cannot tolerate major bypass surgery or percutaneous transluminal coronary angioplasty who meet all of the following criteria: o Presence of class III or IV angina refractory to medical management o Documentation of reversible ischemia o Left ventricular ejection fraction greater than 30% o No evidence of recent myocardial infarction or unstable angina within the past 21 days o No severe comorbid illness such as chronic obstructive pulmonary disease • As an adjunct to coronary artery bypass grafting in those patients with documented areas of ischemic myocardium that are not amenable to surgical revascularization. **Exclusionary Guidelines** • Patients not meeting the inclusion criteria above • Percutaneous transmyocardial laser revascularization
67221, 67225, J3396	**Basic Benefit and Medical Policy** The safety and effectiveness of photodynamic therapy (PDT) with verteporfin for the treatment of choroidal neovascularization has been established. It is a useful therapeutic option for patients meeting patient selection guidelines. All other uses for photodynamic therapy with verteporfin are experimental. Its effectiveness for other indications has not been established. Inclusionary and exclusionary guidelines have been updated, effective March 1, 2012. **Inclusionary Guidelines** Use of Visudyne® followed by laser treatment: Monotherapy of predominantly classic subfoveal CNV (predominantly classic CNV lesions are defined as those in which the classic component comprised 50% or more of the area of the entire lesion) due to: • Age-related macular degeneration • Chronic central serous chorioretinopathy • Choroidal hemangioma • Pathologic myopia **Continued on next page**

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BENEFIT POLICY continued on Page 8

BENEFIT POLICY continued from Page 7

UPDATES TO PAYABLE PROCEDURES	
67221, 67225, J3396 ***Continued***	• Presumed ocular histoplasmosis **Exclusionary Guidelines** • The label notes that there is insufficient evidence for verteporfin use in predominately occult subfoveal CNV, and it is contraindicated. • Use of phototherapy with verteporfin as monotherapy for conditions other than predominantly classic subfoveal choroidal neovascularization due to any of the above conditions • When used in combination with one or more of the anti-vascular endothelial growth factor therapies, including but not limited to pegaptanib (Macugen®), ranibizumab (Lucentis®), bevacizumab (Avastin®), aflibercept (Eylea™) as a treatment of CNV associated with age-related macular degeneration, chronic central serous chorioretinopathy, choroidal hemangioma, pathologic myopia, presumed ocular histoplasmosis or for other ophthalmologic disorders
69930, 92601-92604, L7510, L8614- L8619, L8621- L8624, L8627- L8629	**Basic Benefit and Medical Policy** Exclusionary guidelines updates for cochlear implant are effective March 1, 2013. **Inclusionary Guidelines** **Adults:** A cochlear implant is considered an established, safe and effective therapy if **all** of the following criteria are met: • 18 years of age or older • Bilateral severe to profound sensorineural hearing loss • Limited benefit from appropriately fitted hearing aids (based on speech perception scores) • Evidence of a functioning auditory nerve • Freedom from middle ear infection, lesions in the auditory nerve and acoustic areas of the central nervous system • Accessible cochlear lumen that is structurally suited for implantation • Cognitive ability to use auditory clues and a willingness to participate in a rehabilitation program **Children:** A cochlear implant is considered an established, safe and effective therapy if **all** of the following criteria are met: • 12 months through 17 years of age • Bilateral severe to profound sensorineural hearing • Limited benefit from appropriately fitted hearing aids • Evidence of a functioning auditory nerve • Freedom from middle ear infection, lesions in the auditory nerve and acoustic areas of the central nervous system • Accessible cochlear lumen that is structurally suited for implantation • Motivated child or family who have appropriate expectations and are willing to participate in a rehabilitation program **Continued on next page**

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BENEFIT POLICY continued on Page 9

BENEFIT POLICY continued from Page 8

UPDATES TO PAYABLE PROCEDURES	
69930, 92601-92604, L7510, L8614- L8619, L8621- L8624, L8627- L8629 ***Continued***	In addition, there are criteria associated with the specific cochlear implant used. **Exclusionary Guidelines** • Upgrades of an existing, functioning external system to achieve aesthetic improvement, such as smaller profile components or a switch from a body-worn, external sound processor to a behind-the-ear model.
95965-95967, S8035	**Basic Benefit and Medical Policy** The safety and effectiveness of magnetoencephalography and magnetic source imaging have been established. They may be considered useful diagnostic options when indicated for selected patients**.** Inclusionary and exclusionary criteria updates are effective March 1, 2013. **Inclusionary Guidelines** Magnetoencephalography and magnetic source imaging is considered established in the following situations: • For the purpose of determining the laterality of language function, as a substitute for the Wada test, in patients being prepared for surgery for epilepsy, brain tumors, and other indications requiring brain resection • As part of the preoperative evaluation of patients with intractable epilepsy (seizures refractory to at least two first-line anticonvulsants) when standard techniques, such as MRI and EEG, do not provide satisfactory localization of epileptic lesions **Exclusionary Guidelines** Magnetoencephalography and magnetic source imaging is considered experimental for all indications not listed under the inclusionary guidelines.
A7025, A7026, E0483	**Basic Benefit and Medical Policy** **Inclusionary Guidelines** Effective Jan. 1, 2013, high frequency chest wall oscillation devices are covered for patients who meet Criterion 1, 2, or 3 below and Criterion 4: 1. There is a diagnosis of cystic fibrosis (ICD-9 277.00, 277.02). 2. There is a diagnosis of bronchiectasis (ICD-9 011.50-011.56, 494.0, 494.1, 748.61) that has been confirmed by a high resolution, spiral or standard CT scan and that is characterized by one of the following: • Daily productive cough for at least six continuous months • Frequent (more than two years) exacerbations requiring antibiotic therapy Chronic bronchitis and chronic obstructive pulmonary disease in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion. 3. The patient has one of the following neuromuscular disease diagnoses: • Post-polio (138) • Acid maltase deficiency (277.6) **Continued on next page**

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BENEFIT POLICY continued on Page 10

BENEFIT POLICY continued from Page 9

<table>
<tr><th colspan="2">UPDATES TO PAYABLE PROCEDURES</th></tr>
<tr><td>A7025, A7026, E0483

Continued</td><td>

Anterior horn cell diseases (335.0-335.9)
Multiple sclerosis (340)
Quadriplegia (344.00-344.09)
Hereditary muscular dystrophy (359.0, 359.1)
Myotonic disorders (359.21-359.29)
Other myopathies (359.4, 359.5, 359.6, 359.89)
Paralysis of the diaphragm (519.4)

4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

If all of the criteria are not met, the claim will be denied as not reasonable and necessary.

It is not reasonable and necessary for a patient to use both an HFCWO device and a mechanical in-exsufflation device (E0482).

Replacement supplies, A7025 and A7026, used with patient-owned equipment are covered if the patient meets the criteria listed above for the base device, E0483. If these criteria are not met, claims will be denied as not reasonable and necessary.

Covered for the following conditions as listed above:

011.50 - Tuberculous bronchiectasis, confirmation unspecified
011.51 - Tuberculous bronchiectasis, bacteriological or histological examination not done
011.52 - Tuberculous bronchiectasis, bacteriological or histological examination unknown (at present)
011.53 - Tuberculous bronchiectasis, tubercle bacilli found (in sputum) by microscopy
011.54 - Tuberculous bronchiectasis, tubercle bacilli not found (in sputum) by microscopy, but found by bacterial culture
011.55 - Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological examination, but tuberculosis confirmed histologically
011.56 - Tuberculous bronchiectasis, tubercle bacilli not found by bacteriological or histological examination, but tuberculosis confirmed by other methods [inoculation of animals]
138 - Late effects of acute poliomyelitis
277.00 - Without mention of meconium ileus
277.02 - With pulmonary manifestations
277.6 - Other deficiencies of circulating enzymes
335.0 - Werdnig-Hoffmann disease
335.10 - Spinal muscular atrophy, unspecified
335.11 - Kugelberg-Welander disease
335.19 - Other

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BENEFIT POLICY continued on Page 11

BENEFIT POLICY continued from Page 10

UPDATES TO PAYABLE PROCEDURES	
A7025, A7026, E0483 ***Continued***	• 335.20 - Amyotrophic lateral sclerosis • 335.21 - Progressive muscular atrophy • 335.22 - Progressive bulbar palsy • 335.23 - Pseudobulbar palsy • 335.24 - Primary lateral sclerosis • 335.29 - Other • 335.8 - Other anterior horn cell diseases • 335.9 - Anterior horn cell disease, unspecified • 340 - Multiple sclerosis • 344.00 - Quadriplegia unspecified • 344.01 - C1-C4 complete • 344.02 - C1-C4 incomplete • 344.03 - C5-C7 complete • 344.04 - C5-C7 incomplete • 344.09 - Other • 359.0 - Congenital hereditary muscular dystrophy • 359.1 - Hereditary progressive muscular dystrophy • 359.21 - Myotonic muscular dystrophy • 359.22 - Myotonia congenital • 359.23 - Myotonic chondrodystrophy • 359.24 - Drug-induced myotonia • 359.29 - Other specified myotonic disorder • 359.4 - Toxic myopathy • 359.5 - Myopathy in endocrine diseases classified elsewhere • 359.6 - Symptomatic inflammatory myopathy in diseases classified elsewhere • 359.89 - Other myopathies • 494.0 - Bronchiectasis without acute exacerbation • 494.1 - Bronchiectasis with acute exacerbation • 519.4 - Disorders of diaphragm • 748.61- Congenital bronchiectasis
POLICY CLARIFICATIONS	
57267	**Group Variations** General Motors approved the pelvic organ prolapse repair using synthetic mesh medical policy for GM hourly and salaried employees, effective July 1, 2012. The relative safety and effectiveness of the pelvic organ prolapse repair using synthetic mesh have been established. It may be considered a useful therapeutic option when indicated in carefully selected patients who have been thoroughly advised of possible risks and complications of the procedure.
76376, 76377, 76645	**Basic Benefit and Medical Policy** Procedure codes *76376, *76377 and *76645 are considered experimental when used to report stand-alone ultrasound for routine breast cancer screening. **Continued on next page**

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BENEFIT POLICY continued on Page 12

BENEFIT POLICY continued from Page 11

POLICY CLARIFICATIONS	
76376, 76377, 76645 ***Continued***	These procedure codes may be payable for services other than ultrasound of the breast in an exclusive screening situation. Ultrasound imaging by any method for routine breast cancer screening has not been shown to be an effective alternative to the current standard of care. While breast ultrasound imaging may be a safe and useful supplement to mammography, its clinical utility as a stand-alone routine screening modality has not been scientifically demonstrated. Therefore, stand-alone ultrasound imaging for routine breast cancer screening is experimental, effective March 1, 2013.
EXPERIMENTAL PROCEDURES	
46999, L8605	**Basic Benefit and Medical Policy** The use of injectable bulking agents for the treatment of fecal incontinence is experimental, effective March 1, 2013. There is insufficient evidence in the peer-reviewed scientific literature to demonstrate long-term safety and clinical utility of the use of bulking agents for fecal incontinence.
88299	**Basic Benefit and Medical Policy** Genetic testing for familal cutaneous malignant melanoma (CDKN2A) is considered experimental, effective March 1, 2013. The peer-reviewed medical literature has not yet demonstrated the clinical utility of genetic testing for familial cutaneous malignant melanoma.
88299, S3721	**Basic Benefit and Medical Policy** Genetic tests for the screening, detection and management of prostate cancer are considered experimental, effective March 1, 2013. This includes, but is not limited to the following: • Single-nucleotide polymorphisms for risk assessment • PCA3 for disease diagnosis and prognosis • TMPRSS fusion genes for diagnosis and prognosis • Multiple gene tests (gene panels) for prostate cancer diagnosis • Gene hypermethylation for diagnosis and prognosis
90739	**Basic Benefit and Medical Policy** Effective Jan. 1, 2013, the HEPLISAV™ vaccine is considered experimental. It has not been approved by the FDA.
GROUP BENEFIT CHANGES	
Dort Federal Credit Union	Effective Feb. 1. 2013, Medicare-eligible retirees of the Dort Federal Credit Union will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO[SM] for their medical, surgical and prescription drug benefits. The group number is 59945 with suffix 600. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PPO plan, go to **bcbsm.com/provider/ma.**

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PPO program policies, responsibilities

We want to ensure that you understand the following about our preferred provider organization plans and programs:

- Our quality program
- Our members' rights and responsibilities
- Statement about incentives

We also make this information and additional resources available at **bcbsm.com/importantinfo**.

Guaranteeing quality management

Blue Cross Blue Shield of Michigan conducts quality initiatives to improve health care for our members. You can learn more about our quality program at **bcbsm.com/importantinfo**.

Member rights and responsibilities

Blue Cross Blue Shield of Michigan members have the right to:

- Receive information about their care in a manner that is easy to understand
- Receive medically necessary care as outlined in the *New Member Handbook*
- Receive considerate and courteous care with respect to their privacy and human dignity
- Candidly discuss appropriate medically necessary treatment options for their health conditions, regardless of cost or benefit coverage
- Participate in decision-making regarding their health care
- Review their medical records at your office by scheduling an appointment during regular business hours
- Expect confidentiality regarding their care and that Blue Cross Blue Shield of Michigan adheres to strict internal and external guidelines concerning their personal health information. This includes the use, access and disclosure of that information or any other information that is of a confidential nature.
- Refuse treatment to the extent permitted by law and be informed of the consequences of their actions
- Voice concerns or complaints about their health care by contacting the Customer Service department or submitting a formal, written grievance through the Blue Cross Blue Shield of Michigan appeals process
- Receive clear and understandable written information about Blue Cross Blue Shield of Michigan, its service, practitioners and providers and their member rights and responsibilities
- Make recommendations regarding the member rights and responsibilities policies of Blue Cross Blue Shield of Michigan
- Request the following information from Blue Cross Blue Shield of Michigan:
  - The current provider network in their region
  - The professional credentials of the health care practitioners who are participating with Blue Cross Blue Shield of Michigan, including participating practitioners who are board-certified in the specialty of pain medicine and the evaluation and treatment of pain
  - The names of participating hospitals where individual participating physicians have privileges for treatment
  - How to contact the appropriate Michigan agency to obtain information about complaints or disciplinary actions against a health care practitioner
  - Any prior authorization requirement and limitation, restriction or exclusion by service, benefit or type of drug
  - Information about the financial relationships between Blue Cross Blue Shield of Michigan and a participating practitioner

Blues members have the responsibility to:

- Read all Blue Cross Blue Shield of Michigan materials provided for members, and call our Customer Service department with any questions
- Coordinate all nonemergency care through their primary care physicians
- Use the Blue Cross Blue Shield of Michigan provider network unless otherwise approved by Blue Cross and their primary care physicians
- Comply with the plans and instructions for care that they agreed to with their practitioners
- Provide, to the extent possible, complete and accurate information that Blue Cross Blue Shield of Michigan and its practitioners need in order to provide care
- Make and keep appointments for nonemergency medical care. They must call their doctor's offices to cancel appointments.

PPO Programs continued on Page 14

ALL PROVIDERS

PPO Programs continued from Page 13

- Participate in the medical decisions regarding their health
- Be considerate and courteous to practitioners, providers, their staff and other patients
- Notify Blue Cross Blue Shield of Michigan of address changes and additions or deletions of dependents covered by their contracts
- Protect their identification cards against misuse and contact Customer Service immediately if their cards are lost or stolen
- Report all other health care coverage or insurance programs that cover their health and their family's health
- Participate in understanding their health problems and the development of mutually agreed upon treatment

Statement about incentives

- Utilization management decision-making is based only on appropriateness of care and service and existence of coverage.
- Blue Cross Blue Shield of Michigan does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for utilization management decision-makers do not encourage decisions that result in underutilization.

If you have any questions about any of this information, please contact your provider consultant.

MEDICARE ADVANTAGE

HEDIS medical record reviews begin in February

Each year, Blue Cross Blue Shield of Michigan conducts Healthcare Effectiveness Data and Information Set medical record reviews. Inovalon™ will perform the HEDIS reviews from February through May on behalf of PPO and Medicare Advantage PPO members beginning this month.

These reviews don't replace the risk adjustment medical record review process also performed by Inovalon on behalf of BCBSM's Medicare Advantage PPO.

For the HEDIS reviews, Inovalon looks for details that may not have been captured in claims data, such as blood pressure readings, HbA1c lab results, cholesterol and colorectal screenings, and body mass index. This information helps us enhance our member quality improvement initiatives.

Inovalon will contact you to either schedule an appointment for a HEDIS review or request that you fax the necessary records. BCBSM will reimburse you $5 for each requested medical chart.

The chart below outlines the reviews and when they will be performed:

Review	Reviews scheduled
HEDIS	February through May 2013
Medicare Advantage Risk Adjustment Review Process 1 (FRO 1)	January through March 2013
Medicare Advantage Risk Adjustment Review Process 2 (RRO)	April through May 2013 and October 2013 through January 2014
Medicare Advantage Risk Adjustment Review Process 3 (FRO 2)	June through September 2013

If you have any questions, please contact your provider consultant.

Centers for Medicare & Medicaid Services announce 2013 therapy caps

The Centers for Medicare & Medicaid Services released updated information on change request 8129 for its outpatient therapy caps for 2013. The 2013 therapy cap is $1,900 for physical therapy and speech-language therapy combined. The occupational therapy cap is also $1,900.

For more information, visit the CMS website* to download the *MLN Matters®* overview of the 2013 therapy caps or the related CMS Manual System alert. You can also contact your provider consultant.

*BCBSM does not control this website or endorse its general content.

Reminder: Include rendering practitioner NPI on group provider claims

Please include the rendering practitioner's national provider identifier on any claims originating with group health care providers, including clinics, multi-specialty groups and **physicians providing durable medical equipment or supplies**.

Enter the NPI in field 24J on the CMS-1500 paper claim or in field 2310B/2420A on the 5010 electronic claim.

All applicable fields will require verification with EDI.

Inclusion of the NPI will help us to more quickly process claims. Failure to provide this information may result in claims processing delays or denials.

If you have any questions, please contact your provider consultant.

Reminder: Report numeric amounts in Medicare Advantage claims charge fields

The Centers for Medicare & Medicaid Services require a numeric amount in the charges field of both UB-04 and CMS-1500 claims. Blue Cross Blue Shield of Michigan is not allowed to correct claims.

Home health and skilled nursing facility claims are, at times, submitted with blank charges. Zeros should be included when the forms are completed to initiate a procedure.

Below are links to information on the CMS website explaining each form's guidelines:

- UB-04 – Field 47 overview of total charges required by Medicare: **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ub04_fact_sheet.pdf***
- Medicare Claims Processing Manual, chapter 25, page 23, details field 47 specifically: **cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c25.pdf***
- 1500 – Field 24F overview of total charges required by Medicare: **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/form_cms-1500_fact_sheet.pdf***
- Medicare Claims Processing Manual, chapter 26, page 14, details how Field 24F requires this charge for each listed service: **cms.gov/Regulations-andGuidance/Guidance/Manuals/downloads/clm104c26.pdf***

CMS recently discovered that Medicare's instruction regarding the total charges field report for home health is in conflict with the HIPAA standard 837 institutional claim format. This link below provides additional instructions and clarification: **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7660.pdf***. The 837 requires that the total charges filed (SV203) must always be reported. Zero is an acceptable value.

For skilled nursing facilities, total charges should be zero for revenue code 0022. This link provides additional guidance: **cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf** *.

Thank you for your assistance. If you have any questions, please contact your provider consultant.

*BCBSM does not control this website or endorse its general content.

Reminder: Submit 2012 Medicare Advantage claims

To help ensure accurate and timely claims processing, be sure to submit all claims for Medicare Advantage members with dates of service through Dec. 31, 2012, as soon as possible.

Your assistance in this matter is appreciated. If you have any questions, please contact your provider consultant.

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