March 2013

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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 March issue on Feb. 28.

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

AMA revises psychiatric procedure codes for 2013

The American Medical Association revised coding options for psychiatric evaluations, psychotherapy and pharmacologic management services, effective Jan.1, 2013.

The chart below indicates how you should now bill these services to BCBSM. Please use the 2013 *Current Procedural Terminology* coding guidelines when billing these services.

2012 deleted code*	2013 billing
90801	*90791 or *90792
90802	*90791 or *90792 billed with *90785 (psychotherapy add-on code)
90804	*90832
90805	Appropriate evaluation and management code billed with *90833 (psychotherapy add-on code)
90806	*90834
90807	Appropriate evaluation and management code billed with *90836 (psychotherapy add-on code)
90808	*90837
90809	Appropriate evaluation and management code billed with *90838 (psychotherapy add-on code)
90810	*90832 with *90785
90811	Appropriate evaluation and management code billed with *90833 (psychotherapy add-on code) and *90785 (psychotherapy add-on code)
90812	*90834 with *90785 (psychotherapy add-on code)
90813	Appropriate evaluation and management code with *90836 (psychotherapy add-on code) and *90785 (psychotherapy add-on code)
90814	*90837 with *90785 (psychotherapy add-on code)
90815	Appropriate evaluation and management code billed with *90838 (psychotherapy add-on code) and *90785 (psychotherapy add-on code)
90816	*90832
90817	Appropriate evaluation and management code billed with *90833 (psychotherapy add-on code)
90818	*90834
90819	Appropriate evaluation and management code billed with *90836 (psychotherapy add-on code)
90821	*90837
90822	Appropriate evaluation and management code billed with *90838 (psychotherapy add-on code)
90823	*90832 with *90785 (psychotherapy add-on code)
90824	Appropriate evaluation and management code billed with *90833 (psychotherapy add-on code) and *90785 (psychotherapy add-on code)
90826	*90834 billed with *90785 (psychotherapy add-on code)
90827	Appropriate evaluation and management code billed with 90836 (psychotherapy add-on code) and 90785 (psychotherapy add-on code)
90828	*90837 with *90785 (psychotherapy add-on code)
90829	Appropriate evaluation and management code billed with *90838 (psychotherapy add-on code) and *90785 (psychotherapy add-on code)
90857	*90853 billed with *90785 (psychotherapy add-on code)
No code	New code *90839
No code	New code *90840
90862	Bill using an appropriate evaluation and management code
~~90863~~	*90863 not payable in Michigan

PSYCHIATRIC CODES continued on Page 3

PSYCHIATRIC CODES continued from Page 2

BCBSM reimbursement guidelines
The new psychotherapy codes will be reimbursed at the maximum payment amount based on the current Blue Cross Blue Shield of Michigan fee schedule. The maximum payment amounts for these procedures will be revised during the BCBSM annual review process of all procedures. The updated fee schedule will be available to view April 1 and become effective July 1, 2013.

Psychotherapy add-on codes (noted in the chart) billed with primary psychotherapy codes or evaluation and management codes will be reimbursed as psychiatric services.

When a psychotherapy service is performed during the same session as an E&M service, providers should report the new CPT psychotherapy add-on code in addition to the appropriate E&M service. The psychotherapy add-on code will be rejected if the associated E&M and primary psychotherapy procedure is not reported.

Pharmacologic management should be billed using the appropriate office visit code by physicians who have medication management within their scope of practice. E&M procedure codes billed with psychiatric diagnoses will process as psychiatric services.

For members who do not have mental health coverage through BCBSM, please send E&M procedure codes billed with psychiatric diagnoses to the appropriate mental health care carrier.

We are working diligently to correct the following billing issues:

- Two copays may be applied incorrectly to claims billed with an E&M code and a psychotherapy add-on code (when billed with a primary psychiatric diagnosis). The E&M code will apply an office visit copay, and the psychotherapy code will apply a psychiatric copay. When this occurs, the physician or member may call BCBSM to request an adjustment of the claim. The physician payment will be based on our current fee schedule.
- Claims may be rejected for members who do not have office visit coverage, if an E&M code is billed with a psychiatric diagnosis. When this occurs, the physician or member may call BCBSM to request an adjustment to the claim. If the member has psychiatric coverage, the claim will be reprocessed based on the member's psychiatric benefits. If the member does not have psychiatric coverage, the rejection will be maintained.
- Claims may reject for psychotherapy procedure codes (billed prior to Feb. 7, 2013) *90785, *90791, *90832, *90834, *90837, *90839 and *90840 when billed by a clinical licensed master's social worker. When this occurs, the physician or member may call BCBSM to request an adjustment to the claim. If the member has psychiatric benefits, the claim will be adjusted. If the member does not have psychiatric benefits, the rejection is correct, and the claim will not be adjusted.

If you have questions or experience any additional problems, please contact Provider Inquiry or your BCBSM provider consultant.

Letter explains patient charges for preventive visits that include medical treatment

We're offering a customizable letter on web-DENIS to help explain to patients why they may be responsible for copayments or deductibles connected with their preventive care visits.

We know that Blues members and other patients often question being billed for preventive care visits, because they expect these to be covered 100 percent. But visits that ultimately include treatment of a medical condition may require patient copayments or deductibles for the care that you do not code as preventive.

We've posted a letter to web-DENIS that you may customize for your practice and give to patients to explain your billing responsibilities and their potential copayments in these situations. If you choose to use the letter, we hope it will help educate your patients and reduce the number of questions you receive.

You'll find the letter on web-DENIS:

- Click on *BCBSM Newsletters and Resources*.
- Click on *Newsletters and Resources*.
- Click on *Clinical Criteria and Resources*.
- You'll find the link *Letter to explain patient charges for preventive visits* under the *Resources* heading.

Report national drug code number on professional drug claims for accurate processing

BCBSM is launching an initiative to process professional medical drug claims at the national drug code level with the specific quantity that correlates to the NDC. This means that we'll ask health care providers to submit NDC codes on claims for these drugs, starting May 1, 2013.

This initiative will ensure the most accurate and up-to-date pricing of medical drugs, based on the date of service. Since this is a major change, we are rolling it out in three phases.

The initial phase will begin May 1, when we request you include NDCs and the appropriate quantities on claims for informational purposes. Today, you already submit this information for some medical claims – those reporting not otherwise classified procedure codes J3490 or J3590, for example. During this initial phase, we will continue to process professional medical drug claims based on the procedure code and quantity, to give health care providers time to adjust their billing processes.

The second phase will begin Aug. 1, 2013. At that time, BCBSM will provide a list of drugs we will begin to process at the national drug code level and the specific quantities that correlate with the NDCs.

The third phase will begin Nov. 1. We will require the national drug code on all professional medical drugs claims at that time.

Finding the NDC and Unit of Measure

The national drug code is found on a medication's packaging. An asterisk may appear as a placeholder for any leading zeroes. The container label also displays the appropriate unit of measure for that drug. The unit of measure is by weight (grams: GR), volume (milliliter: ML) (milligram: ME) or count (unit: UN). Each dispensed dose must be converted into one of these, following the manufacturer's unit of measure. International units (F2) must be converted to standard measurements (GR, ML, ME and UN).

- For drugs that come in a vial in powder form that needs to be reconstituted before administration, bill each vial (UN).
- For drugs that comes in a vial in liquid form, bill in milliliters (ML).
- For topical forms of medicine (e.g., cream, ointment, bulk powder in a jar), bill in grams (GR or ME).

Submitting the NDC on claims

Here are some quick tips and general guidelines to assist you with proper submission of valid NDCs and related information on professional claims:

- The NDC must be submitted along with the applicable Healthcare Common Procedure Coding System or Current Procedural Terminology® code.
- The NDC must follow the "5digit4digit2digit" format (11 numeric characters with no spaces or special characters). If the NDC on the package label is fewer than 11 digits, you must add leading zeroes to total 11 digits.
- The NDC must be active for the date of service.
- To submit electronic claims (ANSI 837P), report the following information:

Field name	Field description	ANSI (Loop 2410) – Ref Desc
Product ID Qualifier	Enter "N4" in this field.	LIN02
National Drug CD	Enter the 11-digit NDC assigned to the drug administered.	LIN03
NDC Units	Enter the quantity (number of units) for the prescription drug.	CTP04
NDC Unit / MEAS	Enter the unit of measure of the prescription drug given (GR, UN, ML or ME).	CTP05-1

- To submit paper claims, enter the NDC information in field 24 of the CMS-1500 claim. In the **shaded portion** of field 24A-24G, enter the qualifier "N4" left-justified, immediately followed by the national drug code. Next, enter the appropriate qualifier for the correct dispensing unit (GR, UN, ML or ME), followed by the quantity and the price per unit, as indicated in the example below.
- The format for billing should be:
  N4 + NDC code + 3 Spaces + unit of measure + quantity
  Example: N4555103026710 ML5.5 (See Figure 1 below)
- Reimbursement for discarded drugs applies only to single use vials. Discarded amounts of drugs in multi-use vials are not eligible for payment.
- For home infusion therapy and specialty drugs, health care providers must continue to submit claims with national drug code and National Council for Prescription Drug Programs quantities electronically.

Figure 1

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400173044202 ML2 12.82													N	1B	12345678901
09	01	11	09	01	11	11		J2405		1	25 64	4	N	NPI	0123456789

Behavioral health admission, discharge notification processes change

Blue Cross Blue Shield of Michigan is enhancing its processes and forms for admitting and discharging members seeking behavioral health services.

Magellan Behavioral of Michigan Inc. manages the Blue Cross review process for psychiatric inpatient and partial hospitalizations and hospital-based substance abuse admissions. The authorization process is detailed below.

These changes impact Blues members with Blue Traditional® or PPO coverage. They do not apply to customer groups that have chosen a third party to administer their behavioral health benefits. In addition, select Blue Choice PPO℠ and Federal Employee Program® members are exempt from the faxing process and will continue to require precertification or recertification by telephone for admissions that require authorization. Precertification is not required for partial hospitalization for FEP members.

Changes effective April 1, 2013

We have enhanced the *Facility Admission and Discharge Notification Form* and *Case Management Referral Form.*

As of April 1, 2013, the new form must be used. After April 1, previous versions of the form will not be accepted. Copies of the form are being mailed to facility utilization review directors.

We have also changed how and when the two forms are used.

Facility Admission and Discharge Notification Form

Both Blues-designated and nondesignated facilities are required to use this form for patient admissions and discharges.

- Designated facilities must submit the form to Magellan **within 24 hours** of a patient discharge. The form must be faxed to Magellan at 1-888-656-1132.
- Nondesignated facilities must follow these guidelines:
  - Submit the form to Magellan **within 24 hours** of an admission. The form must be faxed to Magellan at 1-888-656-1132.
  - When a patient's hospital stay is four days or fewer, the facility must fax the discharge information to Magellan on the *Facility Admission and Discharge Notification Form* within 24 hours of discharge.
  - If the length of stay exceeds four days, the facility is required to call Magellan on day five of the admission for a concurrent review.
  - **Facilities must also now submit the form to Magellan within 24 hours of a discharge for admissions that require review by telephone.**

Case Management Referral Form

- The *Case Management Referral Form* has been redesigned to align with the *Facility Admission and Discharge Notification Form*.
- The Blues request that all facilities screen each admission for case management referrals, using the triggers listed on the *Case Management Referral Form.*

You will be able to access both forms online on web-DENIS starting April 1. They should be submitted to Magellan Behavioral of Michigan once completed. The forms include submission instructions.

To download the forms:

1. Log in to web-DENIS.
2. In the left-hand navigation, click on *BCBSM Provider Publications and Resources.*
3. Click on *Newsletters & Resources*.
4. Under "Other Resources," click on *Clinical Criteria & Resources.*
5. In the right-hand column under "Frequently Used Forms," click on the *Facility Admission and Discharge Notification Form* or *Individual Case Management Referral Form*.

If you do not receive the new forms or you have other questions about behavioral health admissions, call Magellan at 1-800-762-2382.

Blues-designated facilities have new patient aftercare requirements

Research by the *American Journal of Medical Quality* shows that "in the absence of timely post-discharge care, patients are 1.5 to 3 times more likely to be re-hospitalized."[1]

To reduce patient readmissions, Blue Cross Blue Shield of Michigan now requires aftercare appointments to be scheduled **within seven days of the patient's discharge.** This is now indicated on the *Facility Admission and Discharge Notification Form*.

Blues-designated facilities are also required to help members with patient appointment scheduling and reminders. We ask that outpatient follow-up is made by calling the patient one to two days after discharge to remind the patient of the appointment, assess if there are any barriers to keeping the appointment and assist if barriers do exist.

In addition to supporting more effective patient recoveries, taking these steps can also lead to a reduction in facility and insurer costs, as well as resource use.

Magellan is facilitating post-discharge appointment compliance for Blue Choice PPO and Federal Employee Program members.

[1]M.J. Orlosky, et al. Improvement of Psychiatric Ambulatory Follow Up Care by Use of Care Coordinators. *American Journal of Medical Quality.* 22 (2007): 95-97.

Beginning April 1, use diagnosis code set in place at time of discharge

As part of our ICD-10 transition, BCBSM has determined that we must change our facility guidelines for reporting the diagnosis code on inpatient claims. Effective April 1, 2013, we are asking our facilities to begin using the diagnosis code sets in place on the date of discharge (instead of the date of admission) for inpatient claims.

This change not only meets the mandated requirement for the ICD-10 transition, but it also aligns our billing guidelines with those of other payers and makes us consistent with the Centers for Medicare & Medicaid Services. Even though the ICD-10 implementation is scheduled for next year, we are making this change now to allow time for our facilities to make the necessary adjustments.

We've heard from some of our facilities that being consistent in which diagnosis code set to use would make it easier to do business with us and help as we all transition to the new code sets.

For more information about billing, check your provider manual on web-DENIS. For more information about the ICD-10 transition, go to **bcbsm.com/icd10**.

Facility precertification request for BCBSM members moving to electronic, fax process

Starting March 1, 2013, Blue Cross Blue Shield of Michigan's Precertification Services department will no longer accept precertification requests by phone.

Requests for precertification and recertification of BCBSM member inpatient admissions (**acute hospital, skilled nursing facility and acute rehab**) must be submitted in the following ways:

- Michigan acute inpatient hospitals should follow the established prenotification process in web-DENIS.
- All facility types can submit requests via the electronic 278 Standard Transaction. If you are interested in utilizing the 278 transaction, email EDICustMgmt@bcbsm.com for assistance.
- All facility types can submit requests via email or fax to the BCBSM Precertification department. Facilities should complete the appropriate facility request form located on BCBSM's provider website at **bcbsm.com/providers/quick-links.html** and fax or email the form as explained below.
  - Acute inpatient hospital requests and Chrysler out of state radiology **only**:
    - Fax 1-866-411-2585
    - Email acuteprecertification1@bcbsm.com
  - Skilled nursing facility and acute inpatient rehabilitation requests:
    - Fax 1-866-411-2573
    - Email continuumofcaresnfandacuterehab@exchange.bcbsm.com
- For MESSA members, call MESSA at the number on the back of the member's ID card to precertify services.

You may submit precertification requests 24 hours a day, seven days a week. Requests will be processed during regular business hours Monday through Friday. Standard turnaround time is four hours. All requests received prior to 4 p.m. Eastern Time will be completed on the same business day. Determinations will be communicated by BCBSM via phone and email.

Please note that precertification is **not required** for:

- Outpatient services and outpatient procedures
- Maternity-related admissions, including cesarean-section
- Observation or short stay
- Durable medical equipment
- Home health care
- Cases in which BCBSM is the secondary insurer (for example, Medicare is primary)

Radiology services must be precertified by calling AIM at 1-800-728-8008. For UAW Retiree Medical Benefits Trust members, call Care Core at 1-888-835-2042.

Please begin using these options as soon as possible. The departmental phone lines will remain open until Thursday, Feb. 28, 2013. Facilities attempting to reach Precertification Services by phone after that day will hear an automated message outlining the appropriate fax submission process and related resources.

Over the next 30 days, we plan to restructure our staffing resources to ensure one-day turnaround during regular business hours to all precertification requests. Members and health care providers who have questions about a specific case or inpatient precertification decision can call 1-866-346-7299 for help.

PRECERTIFICATION continued on Page 7

PRECERTIFICATION continued from Page 6

Soon you will be able to access submission forms and instructions on web-DENIS by clicking *BCBSM Provider Publications and Resources*, then *Newsletters & Resources*. The submission forms and instructions are also available on our BCBSM provider website at **bcbsm.com/providers/quick-links.html**.

Changes to hospital outpatient services reimbursement delayed

Since July 2012, BCBSM has published several articles about reporting of services for the Hospital Outpatient Pricing Strategy II (HOPS II) project effective April 1, 2013. While these reporting guidelines should still be applied effective April 1, 2013, BCBSM's payment for the services will continue on the current methodology and not be converted to a fee basis until Oct. 1, 2013.

Two important exceptions to reporting services, however, are for physical therapy, occupational therapy and speech therapy services and for emergency and trauma services.

- Hospital outpatient – Claims should continue to be reported as they are today, using only revenue codes 0421, 0424, 0431, 0434, 0441 and 0444. Value code 80 should still be reported and series billing rules will also apply.
- Emergency room and trauma E&M services will continue to bundle with surgical services on the claim as they do today.

Changes to freestanding outpatient physical therapy billing delayed

BCBSM is delaying the changes in how freestanding OPTs should report physical therapy, occupational therapy and speech therapy services until Oct. 1, 2013.

Those changes were initially communicated in the November 2012 *Record*. Until Oct. 1, 2013, freestanding OPTs should report PT, OT and ST services as follows:

- Revenue codes 0421, 0424, 0431, 0434, 0441 and 0444 and appropriate HCPCS codes should be reported.
- Revenue codes 0420, 0430 and 0440 should continue to be used to report therapy specific visits.
- Value code 80 should still be reported and series billing rules will also apply.

Remember these tips for billing for clinic evaluation and management services

BCBSM covers services provided in hospital outpatient clinics. Please remember that clinic evaluation and management services are considered services that only physicians can provide and that can only be billed on a professional claim.

As of April 1, 2013, these services should be billed as outlined below:

- The 24 evaluation and management HCPCS codes previously communicated in the December 2012 issue of *The Record* must be billed on a professional claim and the professional group or individual practice PIN should be reported on the claim.
- BCBSM recognizes that other services may be provided in the hospital outpatient clinics by non-physician personnel. Those services can continue to be billed on a facility claim.

It is important to note that some groups do not pay for any services billed with the 051X revenue codes.

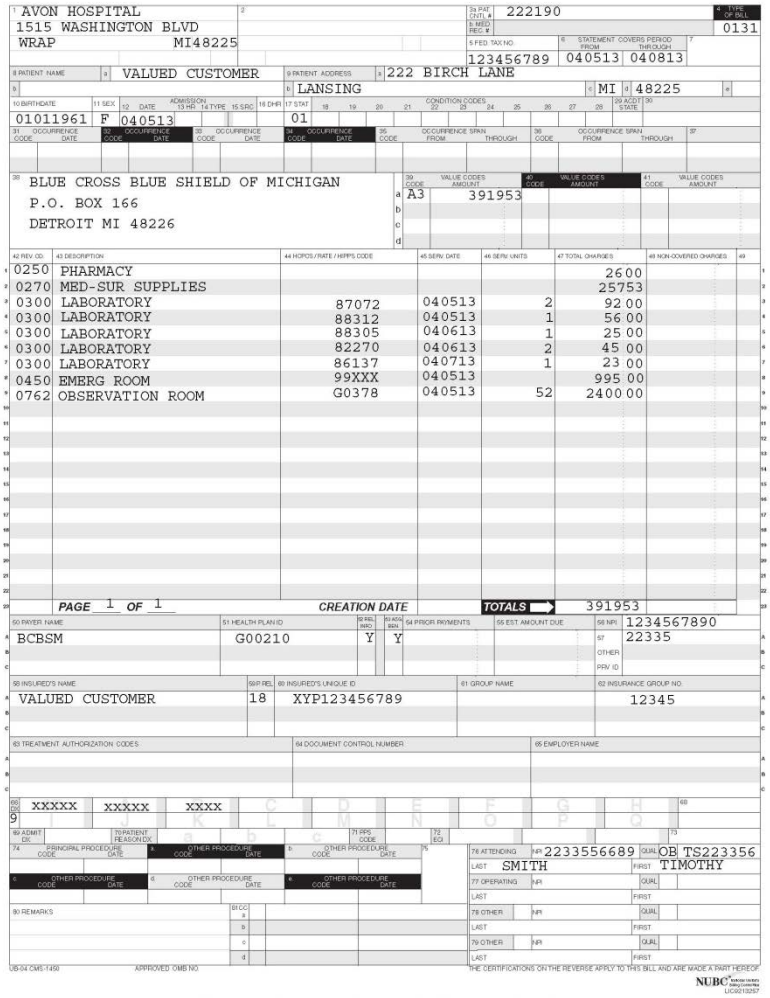
Remember these guidelines when billing for observation services

When billing hospital observation services, please remember to:

- Report the total number of hours of observation care. BCBSM covers up to 48 hours of observation care.
- If a patient is admitted to observation from the emergency room, report all observation hours on one claim line with G0378, using the first date of service the patient entered observation care.
- If a patient was directly admitted for observation care from another setting, report all observation hours on one claim line with G0379, using the first date of service the patient entered observation care.

For observation services, see the following billing instructions and examples for admissions to observation from the emergency room and direct admissions to observation from another setting.

Example – Outpatient medical emergency and observation room spanning more than 48 hours



1 AVON HOSPITAL
1515 WASHINGTON BLVD
WRAP MI48225

3a PAT. CNTL #: 222190
4 TYPE OF BILL: 0131
5 FED. TAX NO.: 123456789
6 STATEMENT COVERS PERIOD: FROM 040513 THROUGH 040813

8 PATIENT NAME: VALUED CUSTOMER
9 PATIENT ADDRESS: 222 BIRCH LANE
LANSING MI 48225

10 BIRTHDATE: 01011961
11 SEX: F
12 DATE: 040513
17 STAT: 01

38 BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 166
DETROIT MI 48226

39 VALUE CODES: a A3
40 VALUE CODES AMOUNT: 391953

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0250	PHARMACY				26 00	
0270	MED-SUR SUPPLIES				257 53	
0300	LABORATORY	87072	040513	2	92 00	
0300	LABORATORY	88312	040513	1	56 00	
0300	LABORATORY	88305	040613	1	25 00	
0300	LABORATORY	82270	040613	2	45 00	
0300	LABORATORY	86137	040713	1	23 00	
0450	EMERG ROOM	99XXX	040513		995 00	
0762	OBSERVATION ROOM	G0378	040513	52	2400 00	

PAGE 1 OF 1 CREATION DATE TOTALS 391953

50 PAYER NAME: BCBSM
51 HEALTH PLAN ID: G00210
52 REL. INFO: Y
53 ASG. BEN.: Y
56 NPI: 1234567890
57 OTHER: 22335

58 INSURED'S NAME: VALUED CUSTOMER
59 P REL: 18
60 INSURED'S UNIQUE ID: XYP123456789
62 INSURANCE GROUP NO.: 12345

66 DX: 9 xxxxx xxxxx xxxx

76 ATTENDING NPI: 2233556689 QUAL: OB LAST: SMITH FIRST: TIMOTHY
77 OPERATING NPI: LAST: FIRST:
78 OTHER NPI: LAST: FIRST:
79 OTHER NPI: LAST: FIRST:

80 REMARKS

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF. NUBC

Outpatient Medical Emergency and Observation Room Spanning More Than 48 Hours

Type of bill (Form Locator 4)
Type of bill "0131" indicates hospital outpatient claim.

Revenue codes (Form Locator 42)
Revenue code "0450" indicates emergency room, and revenue code "0762" indicates observation room.

HCPCS codes (Form Locator 44)
Required for all observation, laboratory, radiology and surgery services. Report G0378 with total number of observation hours and charges. BCBSM covers up to 48 hours of observation care.

Service units (Form Locator 46)
The number of hours spent in observation is required in the service unit form locator when revenue code "0762" is reported.

When a patient stays in the emergency room or observation more than 48 hours or spans two or more calendar days, report the "from" and "through" dates that reflect the patient's entire stay.

Any observation, laboratory, drug, radiology services, etc. should be reported with the actual date service is rendered in Form Locator 45.

All other form locators must be completed as described in the UB-04 manual. Visit National Uniform Billing Committee's website at **nubc.org***.

OBSERVATION SERVICES continued on Page 9

OBSERVATION SERVICES continued from Page 8

Example -- Direct order to admit to observation room

Type of bill (Form Locator 4)
Type of bill "0131" indicates hospital outpatient claim.

Revenue codes (Form Locator 42)
Revenue code "0762" indicates observation room.

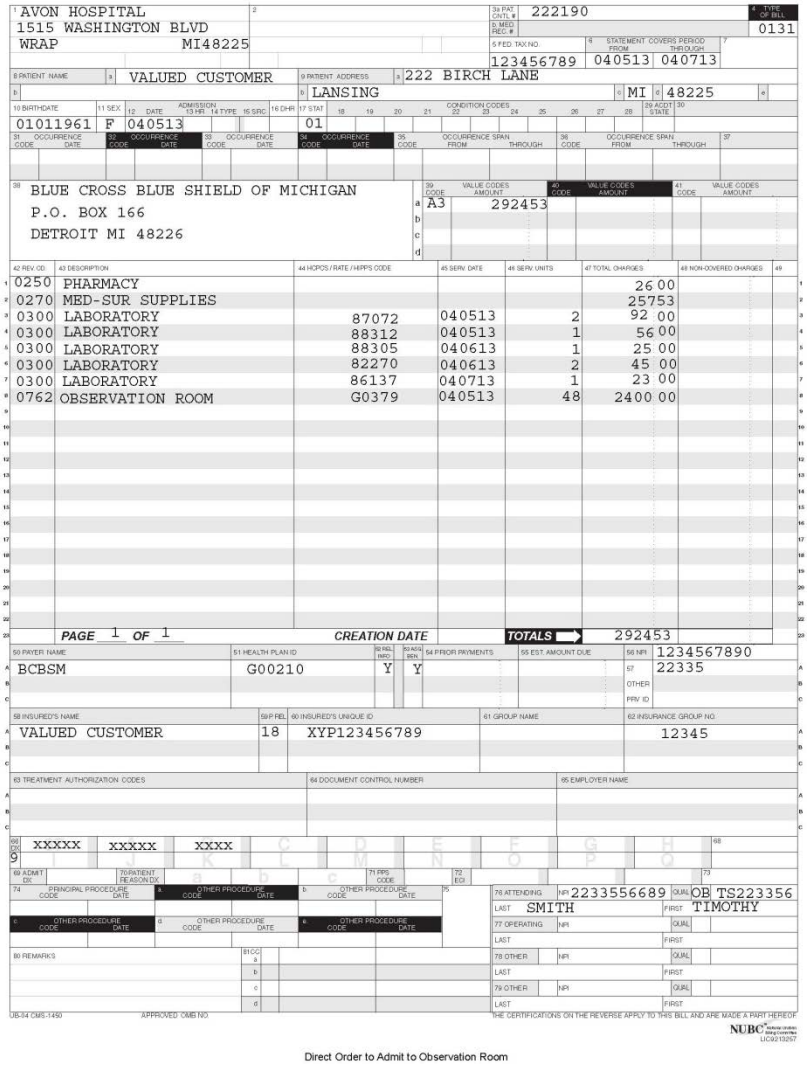
HCPCS codes (Form Locator 44)
Required for all observation, laboratory, radiology and drug services. Report G0379, which indicates direct admit. Report total number of observation hours and charges. BCBSM covers up to 48 hours of observation care.

Service units (Form Locator 46)
The number of hours spent in observation is required in the service unit form locator when revenue code "0762" is reported.

When a patient stays in observation up to 48 hours or spans two or more calendar days, report the "from" and "through" dates that reflect the patient's entire stay. Any observation, laboratory, drug, radiology services, etc. should be reported with the actual date of service rendered in Form Locator 45.

All other form locators must be completed as described in the UB-04 manual. Visit National Uniform Billing Committee's website at **nubc.org***.

For more information about billing, see your health care provider manual on web-DENIS.



1 AVON HOSPITAL
1515 WASHINGTON BLVD
WRAP MI48225

3a PAT CNTL # 222190 — 4 TYPE OF BILL 0131
5 FED. TAX NO. 123456789 — 6 STATEMENT COVERS PERIOD FROM 040513 THROUGH 040713

8 PATIENT NAME: VALUED CUSTOMER
9 PATIENT ADDRESS: 222 BIRCH LANE
LANSING MI 48225
10 BIRTHDATE 01011961 — 11 SEX F — 12 ADMISSION DATE 040513 — 17 STAT 01

39 BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 166
DETROIT MI 48226

39 VALUE CODES a A3 AMOUNT 292453

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0250	PHARMACY				26 00	
0270	MED-SUR SUPPLIES				257 53	
0300	LABORATORY	87072	040513	2	92 00	
0300	LABORATORY	88312	040513	1	56 00	
0300	LABORATORY	88305	040613	1	25 00	
0300	LABORATORY	82270	040613	2	45 00	
0300	LABORATORY	86137	040713	1	23 00	
0762	OBSERVATION ROOM	G0379	040513	48	2400 00	

PAGE 1 OF 1 — CREATION DATE — TOTALS 292453

50 PAYER NAME: BCBSM — 51 HEALTH PLAN ID: G00210 — 52 REL. INFO Y — 53 ASG. BEN Y — 54 PRIOR PAYMENTS — 55 EST. AMOUNT DUE — 56 NPI 1234567890 — 57 OTHER PRV ID 22335

58 INSURED'S NAME: VALUED CUSTOMER — 59 P REL 18 — 60 INSURED'S UNIQUE ID XYP123456789 — 61 GROUP NAME — 62 INSURANCE GROUP NO. 12345

63 TREATMENT AUTHORIZATION CODES — 64 DOCUMENT CONTROL NUMBER — 65 EMPLOYER NAME

66 DX 9 — XXXXX XXXXX XXXX — 68

69 ADMIT DX — 70 PATIENT REASON DX — 71 PPS CODE — 72 ECI — 73

74 PRINCIPAL PROCEDURE CODE DATE — a. OTHER PROCEDURE CODE DATE — b. OTHER PROCEDURE CODE DATE — 75
c. OTHER PROCEDURE CODE DATE — d. OTHER PROCEDURE CODE DATE — e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI 2233556689 QUAL OB TS223356 — LAST SMITH — FIRST TIMOTHY
77 OPERATING NPI QUAL — LAST FIRST
78 OTHER NPI QUAL — LAST FIRST
79 OTHER NPI QUAL — LAST FIRST

80 REMARKS — 81 CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. — THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF — NUBC LIC0213257

Direct Order to Admit to Observation Room

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

Blue Cross Blue Shield of Michigan adds new approved autism evaluation centers

The Blues have added new centers to its list of approved autism evaluation centers. Here are the five AAECs:

- Henry Ford Center for Autism and Developmental Disabilities, Detroit
- Spectrum Health Medical Group, Grand Rapids
- University of Michigan Health System, Ann Arbor
- Oakwood Center for Exceptional Families, Dearborn
- Children's Hospital of Michigan Autism Center, Detroit

BCBSM health care providers can find the latest information about Blues autism coverage online. For more information, visit web-DENIS and follow these instructions:

- Click on *BCBSM Provider Publications and Resources*
- Click on *Newsletters & Resources*
- Under *Other Resources*, click on *Clinical Criteria & Resources*
- Under *Resources*, click on *Autism*

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The latest list of approved autism evaluation centers is always available on **bcbsm.com**. Members can find it by clicking on *Find a Doctor* and then *Approved Autism Evaluation Centers and Board Certified Behavior Analysts* (PDF), under *Additional Directories*.

Autism treatment billing guidelines change
In the December issue of *The Record*, we provided the billing and procedure information pertinent to behavior analysts who participate with the Blues to provide autism treatment. We want to update you on a change to the detailed billing guidelines for supervision quantity limits.

Behavior analysts should report supervision code G9012 in quantities **per 15 minutes**, with a quantity limit of 12. A board-certified behavior analyst may bill up to three hours of supervision per tutor per patient per week. A board-certified behavior analyst may bill for the supervision of the parent- and educator-tutors under this code.

We previously stated the quantity limit was calculated **per hour**.

The chart below has the updated detailed billing guidelines:

Activity and details	Code	Rate*	Billing	Documentation
Initial assessment	H0032	Per hour	Providers need to bill the number of units that correspond to the number of hours spent during the initial assessment. Example: If the initial assessment takes eight hours, the provider needs to bill eight units of H0032.	Providers must document objective performance metrics in the patient record.
Reassessment In practice, this activity may occur anywhere from monthly to annually. Reassessments are typically done on a semi-annual basis.	H0031	Per hour	Providers need to bill the number of units that correspond to the number of hours spent during the reassessment. Example: If the reassessment takes four hours, the provider needs to bill four units of H0031.	Providers must document progress on the performance metrics established during the initial assessment in the patient record.
Line therapy Services are provided by a tutor who needs no particular licensing or training beyond that provided by the BCBA and who may have a high school, associate's or bachelor's degree.	H2019	Per 15 minutes	BCBA needs to bill for the hours of direct interaction the tutors have with the member. BCBA may not bill for relatives or guardians performing tutoring services. Because the code is per 15 minutes, provider must bill the correct number of units to correspond with the total time spent with the patient. Example: If a member receives 2.5 hours of tutoring, the BCBA needs to bill 10 units of H2019.	NA
Supervision Supervision is "eyes-on" during a line therapy (tutoring) session and includes time afterward to process feedback and make adjustments to the treatment plan.	G9012	Per 15 minutes	Quantity limit: BCBA may bill up to three hours per tutor per patient per week (quantity unit of 12). BCBA may bill for the supervision of the parent- and educator-tutors under this code.	NA

Qualified facilities can still apply for AAEC designation
The Blues continue to seek additional qualified facilities that are interested in receiving the approved autism evaluation center designation. More information can be found on web-DENIS in *BCBSM Provider Publications and Resources,* on our autism page.

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AUTISM EVALUATION CENTERS continued from Page 10

We're still seeking board-certified behavior analysts, too. Visit **bcbsm.com/provider** and follow these instructions to find the enrollment form and agreements:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters & Resources.*
- Under *Other Resources*, click on *Clinical Criteria & Resources.*
- Under *Resources*, click on *Autism.*

For more information, contact your provider consultant. If you're unsure who your provider consultant is, call the appropriate manager below:

- Southeast Michigan: Laurie Latvis, 313-225-7778
- Mid-Michigan: Kathryn Simon, 517-325-4590
- West and Northern Michigan: Shaun Raleigh, 616-389-8141
- Upper Peninsula: Mike Fedrizzi, 906-228-5457

HCPCS codes added, coverage decisions changed

The Centers for Medicare & Medicaid Services has added one new HCPCS code as part of its first quarter HCPCS update. CMS has also rescinded one modifier released as part of its 2013 annual update and changed coverage decisions for five HCPCS codes.

The new code is listed below.

Code	Change	Coverage Comments	Effective Date
G9157	Added	Covered by BCBSM	Oct. 1, 2012

Corrections to the 2013 annual HCPCS update
BCBSM published new and deleted codes for 2013 on web-DENIS in January. We listed Modifier 18 as a new modifier there in error.

BCBSM has changed its coverage decisions for the following codes, effective Jan. 1, 2013.

*Code	Change	Coverage Comments	Effective Date
0318T	Added	Requires manual review	Jan. 1, 2013
23473	Added	Covered by BCBSM	Jan. 1, 2013
23474	Added	Covered by BCBSM	Jan. 1, 2013
24370	Added	Covered by BCBSM	Jan. 1, 2013
24371	Added	Covered by BCBSM	Jan. 1, 2013

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.

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BENEFIT POLICY CHANGES continued from Page 11

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	
A4216, A4217, A4605, A4624, A4628, A7000- A7002, E0600, E2000, K0743-K0746	**Inclusionary Guidelines** **Gastric Suction** A gastric suction pump (E2000) is used to remove gastrointestinal fluids under continuous or intermittent suction via a tube. Use of a gastric suction pump and related supplies are covered for members who are unable to empty gastric secretions through normal gastrointestinal functions. Use of a gastric suction pump for other conditions will be denied as not reasonable and necessary. Supplies (tubing, tape, dressings, etc.) are covered and are separately payable when they are medically necessary and used with a medically necessary E2000 pump. Supplies used with DME that is denied as not reasonable and necessary will also be denied as not reasonable and necessary. **Respiratory Suction** A respiratory suction pump (E0600) is covered for members who have difficulty raising and clearing secretions secondary to: • Cancer or surgery of the throat or mouth • Dysfunction of the swallowing muscles • Unconsciousness or obtunded state • Tracheostomy Use of a respiratory suction pump for other conditions will be denied as not reasonable and necessary. Suction catheters (A4605, A4624, A4628) and sterile water or saline (A4216, A4217) are covered and are separately payable when they are medically necessary and used with a medically necessary E0600 pump. Supplies used with DME that are denied as not reasonable and necessary will also be denied as not reasonable and necessary. (Continued)

BENEFIT POLICY CHANGES continued on Page 13

BENEFIT POLICY CHANGES continued from Page 12

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
UPDATES TO PAYABLE PROCEDURES	
A4216, A4217, A4605, A4624, A4628, A7000- A7002, E0600, E2000, K0743-K0746 (continued)	Procedure codes A4605 and A4624 are only covered for members with a tracheostomy (ICD-9 codes 519.00, 519.01, 519.02, 519.09, V44.0 or V55.0) as described below: • Tracheal suction catheters (A4624) are reasonable and necessary only when all of the following are met: - The member has a tracheostomy described by the listed diagnosis codes. - The member requires the use of a covered respiratory suction pump (E0600) as described above, for tracheostomy suctioning. • Closed system catheters (A4605) are reasonable and necessary only when all of the following are met: - The member has a tracheostomy described by the listed diagnosis codes. - The member requires the use of a covered respiratory suction pump (E0600) as described above, for tracheostomy suctioning. - The member requires the use of a covered ventilator. (Refer to CMS' Internet Only Manual 100-3, CH 1, §280.1 for information about the coverage of ventilators.) Claims for A4605 and A4624 suction catheters that do not meet all of the criteria above will be denied as not reasonable and necessary. More than three A4624 catheters per day will be denied as not reasonable and necessary for tracheostomy suctioning. Non-tracheal suction catheters (A4628) are reasonable and necessary for suctioning in the oropharynx. The oropharynx is not sterile, therefore the catheter can be reused if properly cleansed or disinfected. More than three catheters (A4628) per week will be denied as not reasonable and necessary for oropharyngeal suctioning. Sterile water or saline solution (A4216, A4217) is covered when used to clear a suction catheter after tracheostomy suctioning. Sterile water or saline will be denied as not reasonable and necessary when used for oropharyngeal suctioning. **Wound Suction** Use of suction on wounds (A9272, K0743) is only appropriate in those clinical scenarios where the quantity of exudate exceeds the capacity of conservative measures such as surgical dressings and wound fillers to contain it. (Continued)

BENEFIT POLICY CHANGES continued on Page 14

BENEFIT POLICY CHANGES continued from Page 13

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
UPDATES TO PAYABLE PROCEDURES	
A4216, A4217, A4605, A4624, A4628, A7000- A7002, E0600, E2000, K0743-K0746 (continued)	However, wound suction to remove exudate can be accomplished with the use of noncovered disposable, suction devices (A9272) or with covered DME devices (K0743). When a noncovered alternative exists (A9272), it is not reasonable or necessary to use a covered DME item (K0743). Therefore, when K0743 is billed, it will be denied as not reasonable and necessary. Refer to the Local Coverage Article for Suction Pumps for additional information about the statutory requirements for disposable wound suction items (A9270, A9272). Wound suction pumps and their associated supplies, which have not been specifically designated as being qualified to use HCPCS code K0743 via written instructions, will be denied as not reasonable and necessary. Supplies (dressings, tubing, etc.) are covered and are separately payable when they are medically necessary and used with a medically necessary K0743 pump. Supplies used with DME that are denied as not reasonable and necessary will also be denied as not reasonable and necessary. **Refill Requirements** For durable medical equipment, prosthetics, orthotics, and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DME/P&O products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the member. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion and to confirm any changes or modifications to the order. Contact with the member or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery or shipping date. For delivery of refills, the supplier must deliver the DME/P&O product no sooner than 10 calendar days prior to the end of use for the current product. This is regardless of which delivery method is used. (CMS Program Integrity Manual, Internet-Only Manual, CMS Pub. 100-8, Chapter 5, Section 5.2.6). For all DME/P&O items that are provided on a recurring basis, suppliers are required to have contact with the member or caregiver prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request from a member. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary. (Continued)

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BENEFIT POLICY CHANGES continued from Page 14

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
UPDATES TO PAYABLE PROCEDURES	
A4216, A4217, A4605, A4624, A4628, A7000- A7002, E0600, E2000, K0743-K0746 (continued)	Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers must stay attuned to changed or atypical utilization patterns on the part of their clients. Suppliers must verify with the ordering physicians that any changed or atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three-month quantity at a time. **Diagnoses required for A4605 and A4624:** 519.00 – Tracheostomy complication unspecified 519.01 – Infection of tracheostomy 519.02 – Mechanical complication of tracheostomy 519.09 – Other tracheostomy complications V44.0 – Tracheostomy status V55.0 – Attention to tracheostomy
GROUP BENEFIT CHANGES	
Charter Township of Chesterfield	Effective March 1, 2013, Medicare-eligible retirees of the Charter Township of Chesterfield will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 60022 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.**
Charter Township of Kalamazoo	Effective March 1, 2013, Medicare-eligible retirees of the Charter Township of Kalamazoo will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 59957 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**.
Jackson County Medical Care Facility	Effective March 1, 2013, Medicare-eligible retirees of the Jackson County Medical Care Facility will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 59981 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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BENEFIT POLICY CHANGES continued from Page 15

Group Name	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
GROUP BENEFIT CHANGES	
Purity Cylinder Gasses Inc.	Effective March 1, 2013, Medicare-eligible retirees of Purity Cylinder Gasses Inc. will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 60029 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**.
Van Buren County Road Commission	Effective March 1, 2013, Medicare-eligible retirees of the Van Buren County Road Commission will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 59993 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**.
W. E. Upjohn Institute	Effective March 1, 2013, Medicare-eligible retirees of the W. E. Upjohn Institute will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 59988 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**.

Reminder for home health care to bill visits, not hours

Please remember, home health care agencies should bill BCBSM for services by using the number of visits (not hours or increments of hours) as a unit of service. When billing on a UB-04 claim, section 46 requests units, and one unit of service equals one visit.

In the rare instances where an initial home health assessment is done on the same day as a skilled nursing visit, BCBSM's audit area will look for two separate sets of documents that can substantiate the medical necessity for both visits.

Please keep in mind that when billing for an initial home health assessment visit, that is the only service that can be billed during that visit.

For more information about billing, see your provider manual on web-DENIS.

ALL PROVIDERS

Michigan Conference of Teamsters Welfare Fund behavioral health benefits to be managed by Magellan

The Michigan Conference of Teamsters Welfare Fund will begin using the BCBSM behavioral health program April 1, 2013. This means that behavioral health and substance abuse benefits will be managed by Magellan Behavioral of Michigan, instead of ValueOptions.

Members will receive new ID cards indicating this change. If you or a member has questions concerning these benefits, call Magellan at 1-800-762-2382.

AUTO GROUPS

URMBT members with certain conditions may be required to work with nurse case managers

The UAW Retiree Medical Benefits Trust may require a member to work with a Blue Cross Blue Shield of Michigan nurse case manager to ensure coverage for certain conditions that are complex, severe or rare.

This requirement is part of the Mandatory Case Management Program, which was designed to help improve care quality and coordinate health care services for URMBT members. The requirement took effect Jan. 1, 2012.

If a member selected for the program refuses to participate, the plan's portion of the financial obligation for medical services, treatments, situations, prescription drugs or other services related to the condition may not be covered. For members enrolled in Medicare Parts A and B, we anticipate that Medicare will cover its portion of the financial obligation, regardless, since Medicare does not require case management.

Here's how the program works:

- Members selected for the MCM program will receive a certified introduction letter explaining the program and participation requirements.
- Physicians will receive an introduction letter notifying them of their patients who have been selected for the program.
- A BCBSM physician consultant will contact the member's primary care physician or specialist to identify any barriers that may prevent medical stability, help to provide coordination of care and develop a plan of action to meet the patients' health care goals and reduce unnecessary utilization.
- Designated nurse case managers will work with the members to coordinate health services, find community resources, provide information, answer questions and help members meet their established treatment plan goals.
- Members will participate in regularly scheduled calls with the nurse case managers to monitor adherence to their treatment plans.

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

MEDICARE ADVANTAGE

Clarification: Certificate of medical necessity required for only seat lift mechanism

In the January issue of *The Record*, in the article titled "Medicare Advantage durable medical equipment coverage changes," we reported that a certificate of medical necessity was required for patient lifts. The CMN requirement is only for the **seat lift mechanism** portion of what is commonly referred to as a lift chair.

A CMN is a form the physician must complete and submit with a DME prescription. It certifies the member's condition is such that the DME being prescribed is medically necessary. If a DME supplier bills for items requiring a certificate of medical necessity, the supplier must bill with the KX modifier to indicate a certificate is on file.

We apologize for any confusion this may have caused. If you have any questions, please contact your provider consultant.

New report to help primary care physicians achieve new Diagnosis Closure incentive

A new Blues Medicare Advantage Diagnosis Closure incentive program for primary care physicians was announced in the January issue of *The Record*. A new report is expected to be available on Health e-Blue℠ by the beginning of March.

The new report will be called *Panel – Diagnosis Evaluation* and will include Medicare Advantage patients who have historical or suspected conditions but the diagnosis has not been submitted to the Blues yet in the current year. Watch for an update on Health e-Blue with more information.

The report will include:

- Reported diagnoses in the current year, including all diagnoses reported to the Blues for each patient in the calendar year
- A list of all historical diagnoses reported in prior years and suspected conditions based on pharmacy claims, medical claims or other supplemental data sources
- The report allows the physician to submit additional diagnoses, along with the date the patient was seen in the office, or to indicate that the patient does not have a suspected diagnosis
- A section for the physician's electronic signature

All diagnoses reported must be:

- Based on a face-to-face visit with the patient in 2013
- Addressed with the patient during the face-to-face visit
- Documented in the patient's medical record following the Centers for Medicare & Medicaid Services guidelines

This information may be audited by the Blues or by CMS.

Note: The Blues will not provide a paper Diagnosis Evaluation form on web-DENIS as previously communicated. The form will be available solely on Health e-Blue as part of the report described in this article.

Obtaining access to Health e-Blue

If your primary care office does not have access to Health e-Blue, apply today. Go to **bcbsm.com/provider**, then:

1. Click on *web-DENIS*
2. Click on *Provider Secured Services*
3. Under *Solutions* available through Provider Secured Services, click on *Health e-Blue for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data.*

Performance Recognition Program for Medicare Advantage PPO providers continues in 2013

BCBSM is continuing the Medicare Plus Blue PPO℠ Performance Recognition Program for 2013.

The program design remains unchanged from 2012.

The program recognizes your efforts to improve Medicare Advantage members' health. Furthermore, it encourages your patients to take more active roles in their health and wellness. The Performance Recognition Program uses the Health e-Blue℠ online tool that gives you easy access to member data related to the program's performance measures.

This tool allows viewing of the health registry, utilization of services and pharmacy information for our members. This enables you to remind and encourage your patients to obtain preventative services such as mammograms or eye exams.

The program has three main components:

Base PRP — The base PRP is a target based on certain preventive screenings and disease management measures. The measurement period runs January 2013 through December 2013. You receive the base PRP payment in July 2014.

Pay As You Go — This component focuses on Healthcare Effectiveness Data and Information Set measures. The measurement period is January 2013 through December 2013. You receive payments in October 2013 and June 2014 for services completed during 2013.

PRP Bonus — Bonuses are based on HEDIS measures within a specified measurement period. This bonus is paid once a year in June 2014.

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PERFORMANCE RECOGNITION continued from Page 18

Please visit the Health e-Blue home page (log in through Provider Secured Services) for all 2013 physician recognition information, including the specific metrics for each PRP component.

If you do not have access to Health e-Blue, contact your provider consultant who will facilitate immediate access. Please contact your provider consultant or Provider Relations manager below and they will assist in answering any questions you may have about the program.

Southeast Region
Laurie Latvis
Phone: 313-225-7778
Email: llatvis@bcbsm.com

West Region
Shaun Raleigh
Phone: 616-389-8141
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Central (Mid and East) Region
Kate Simon
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Upper Peninsula Region
Michael Fedrizzi
Phone: 906-228-5457
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Medicare Advantage preventive care planner mailed to patients

We've developed a preventive care planner for Blue Cross Blue Shield of Michigan Medicare Advantage patients to help them plan their preventive care and make time for wellness. We ask that you encourage your patients to bring the planners to their visits and use them throughout the year for support in managing and tracking health care needs.

The BCBSM 2013 preventive care planner was recently mailed, and will help Medicare Advantage patients track medical services, tests, screenings, medications and appointments.

The planner includes a checklist that reminds patients to schedule preventive tests focused on such areas as:

- Blood pressure
- Bone mass measurement
- Cholesterol
- Glaucoma
- Glucose
- Pelvic or prostate health

The planner reminds patients that only their doctors can help them determine the appropriate test options and frequency. The planner also includes vaccine reminders for flu, hepatitis B, pneumonia and shingles, and encourages patients to talk with their physicians about:

- Exercise and physical activity
- Body mass index
- Memory and mental health
- Bladder control
- Risks of slipping and falling
- Age-related medication risks
- Diabetes
- Angiotensin converting enzyme inhibitors and angiotensin receptor blocker drugs for controlling blood pressure

BCBSM values the quality patient care that Blues' participating physicians consistently demonstrate. We hope this new tool will support physicians' efforts to improve the health of their patients and enhance the patient-doctor dialogue.

To view the preventive planner and learn more, log in to web-DENIS:

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters & Resources*.
- Click on *Medicare Advantage Resources.*

If you have questions, please contact your provider relations manager:

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Laurie Latvis
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A provider publication produced by the Corporate Communications Division of Blue Cross Blue Shield of Michigan. Published monthly for participating health care providers and their office staffs. Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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