April 2013

Articles in this issue…

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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 April issue on March 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*.

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- Click on *I am a Provider*.
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The Record
Corporate Communications – Mail Code 0245
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226

BCBSM to change professional provider fees July 1

BCBSM will change practitioner fees, effective with dates of service on or after July 1, 2013, for services provided to our Traditional, TRUST and Blue Preferred Plus℠ members, regardless of customer group.

BCBSM will use the 2013 Medicare resource-based relative value scale for all relative value unit-priced procedures for dates of service on and after July 1. Most fees are currently priced using the 2012 values.

Changes in RBRVS values can impact fees. Procedure code maximum fees will increase or decrease based on the new relative value units and BCBSM's conversion factors.

At the same time, the non-RVU-based anesthesia services will be increased by 1.3 percent in West Michigan and the rest of the state.

We conduct a comprehensive analysis of professional provider performance and current economic indicators annually to calculate practitioner fees, with consideration for corporate and customer cost concerns. BCBSM remains committed to reviewing professional provider performance to determine the need for increases or decreases in our maximum payments.

Fee schedules with the new fees that are effective July 1 will be available on web-DENIS April 1. Click on *Entire Fee Schedules and Fee Changes* on the web-DENIS *BCBSM Provider Publications and Resources* page to find fee information.

Please do not resubmit claims with dates of service prior to July 1, 2013. Only claims submitted with dates of service on or after July 1 will be reimbursed at the new rates.

For more information, contact your BCBSM provider consultant.

Physician incentive component to increase for most codes

Effective July 1, 2013, the Physician Group Incentive Program physician organization reward component of professional fees will increase to 5.0 percent for most procedure codes, except those for durable medical equipment, prosthetics and orthotics, anesthesia, immunizations, hearing, vision and most injections.

The current physician organization component used to fund the incentive program is 4.7 percent.

Our innovative physician incentive program rewards performance and best practices, and is designed to improve the quality of patient care while helping to reduce costs.

Here's what you will see on your claims payment vouchers. BCBSM pays the physician the **approved amount** that is based on our established fee schedule.

At the same time, the voucher shows an additional **physician organization component amount** (5.0 percent) for PGIP incentives, which is available to PGIP POs. These are dollars exclusively devoted to the PGIP incentive pool and are **not** intended as fee schedule reimbursement. The dollars are **not** taken out of the **approved** amount that is paid to the health care provider.

Combined, they add up to the **allowable amount**. The allowable amount is our way of tracking — on an individual claim basis — the separate amounts we spend on physician reimbursement and PGIP. All funds from the PGIP incentive pool are distributed to the PGIP physician organizations to support physician practice transformation. No money is retained by BCBSM for administrative costs.

Note: Claims for Federal Employee Program® members are excluded from the Physician Group Incentive Program.

For more information on the Physician Group Incentive Program, please contact your provider consultant. You can also find information about PGIP at **bcbsm.com/provider/value_partnerships/pgip**.

Policy regarding infusion of substances considered not medically necessary by BCBSM

BCBSM carefully considers whether procedures, services, substances, treatments and medications are deemed medically necessary. BCBSM has determined that certain infused substances do not meet our standards of medical necessity; therefore, you may not submit claims for these substances.

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Examples of these types of infused substances include: Meyer's solution or other homeopathic medicines, "mega" doses of vitamins and vitamin B12 in patients without documented B12 deficiency.

When you infuse substances that we consider not medically necessary, you may not submit claims for related infusion services, for example, CPT codes *96365 and *96366.

In addition, if you employ systems of care using diagnostic and treatment methods that we consider not medically necessary, you may not submit claims for services provided in this context, even if the same services would be payable in the context of a medically necessary treatment plan. Examples of services that are not payable in this situation include laboratory testing and evaluation and management services.

If you are a BCBSM-contracted health care provider and intend to provide services to our members that we consider not medically necessary, you must notify our member before delivering the service that it is not covered by BCBSM. The member will be personally responsible for payment. BCBSM will not reimburse the member for these services.

If you do not inform your patient (our member) about noncovered proposed treatments, we will consider it a violation of our Traditional Participating Provider Agreement and our PPO TRUST Agreement. Violation of these contracts is grounds for termination of your BCBSM provider agreements.

Health reform law requires Blues providers to meet PPO accreditation standards

According to the Patient Protection and Affordable Care Act, Blue Cross Blue Shield of Michigan must be accredited to offer any PPO product in the Health Insurance Marketplace*. To qualify for PPO accreditation, we have to meet the requirements of the National Committee for Quality Assurance.

As such, we are asking our participating doctors and other health care professionals to immediately begin following NCQA standards. These include those listed in the table at right. They indicate the maximum wait time allowed for patients, beginning at the time the patient calls the doctor or hospital.

We'll conduct annual surveys to determine whether providers are complying with the standards. We will also notify you of other NCQA requirements.

*The Health Insurance Marketplace was formerly known as the Health Insurance Exchange. The name was changed recently by the U.S Department of Health and Human Services.

Non-behavioral health

Treatment	Standard
Preventive care (no symptoms)	30 business days
Routine (symptoms are not urgent)	10 business days
Urgent (acute symptoms)	48 hours
Emergency Care	Immediately
Waiting room time	30 minutes

Behavioral health

Treatment	Standard
Routine	10 business days
Urgent	48 hours
Emergency (not life-threatening)	6 hours
Life-threatening emergency	Immediately
Waiting room time	30 minutes

Blue Cross measures and promotes clinical effectiveness for mental health treatment

Blue Cross Blue Shield of Michigan is committed to improving the quality of mental health treatment delivered to our members. To that end, we are taking the following actions:

- Encouraging doctors and other health care professionals to follow treatment standards developed by the Michigan Quality Improvement Consortium and Blue Cross

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- Tracking certain aspects of care quality by using measures within the Healthcare Effectiveness Data and Information Set, also known as HEDIS

HEDIS measures
HEDIS provides four major measures related to behavioral health services, including:

- **Follow-up after hospitalization for mental illness (FUH7):** Proportion of patients discharged from a mental health facility who are seen by a mental health care provider within seven days of discharge
- **Antidepressant medication management:** Proportion of newly diagnosed depressed adults who receive an antidepressant:
    1. For 12 weeks (acute phase)
    2. For six additional months (continuation phase)
- **Follow-up care for children prescribed attention deficit hyperactivity disorder medication:** Proportion of children prescribed medication for ADHD who receive:
    1. At least one follow-up visit within 30 days of medication initiation
    2. At least two additional visits within the next seven months
- **Initiation and engagement of alcohol and other drug dependence treatment:** Proportion of patients diagnosed with alcohol and other drug dependencies who receive treatment within 14 days, followed by two additional services within 30 days

The Blue Cross Physician Group Incentive Program has endorsed two of the HEDIS-based behavioral health measures related to depression medication and follow-up for patients with ADHD in its tracking initiative (Evidence-Based Care Reports).

Michigan Quality Improvement Consortium standards
MQIC has two guidelines directed to mental health concerns, including:

- **Primary care diagnosis and management of adults with depression:** This guideline addresses key components of detection and diagnosis using validated screening tools (PHQ-2 and PHQ-9) and criteria from the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV). It includes recommendations for screening for suicidal risk and management of patients on antidepressant medication (including conditions and circumstances in which referral to a behavioral health specialist is advised).
- **Screening, diagnosis and referral for substance use disorders**: This guideline should be followed at every health maintenance exam or initial pregnancy visit. It also includes the HEDIS standards of treatment initiation and follow-up within 14 and 30 days, respectively.

You can find all of the MQIC guidelines at **MQIC.org*.**

Diagnosis and management of Attention Deficit Hyperactivity Disorder
Blue Cross Blue Shield of Michigan's clinical practice guideline on diagnosing and managing ADHD summarizes:

- The core symptoms leading to detection and diagnosis
- Elements of nonpharmacological management and proper initiation of pharmacotherapy (beginning with stimulants as first-line therapy)
- Common comorbid conditions frequently seen with ADHD

This guideline may be found on web-DENIS in the online provider manuals in the "Best Practices" chapter.

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

Online prior authorization training delayed until July

The Blues program requiring prior authorization of physician-administered specialty drugs will move to a secure online request system later this year. We have delayed training on use of the online system until July.

The new online request tool will be administered by our vendor, NovoLogix. It will be available for use July 22, after a pilot phase with a small group of physicians. In preparation for using this tool, we will offer online video training and hour-long question and answer sessions.

In January, we told you this training was scheduled for March.

Training is for health care practitioners who prescribe physician-administered specialty drugs. These practitioners will have access to the NovoLogix online tool for requesting prior authorization. Health care providers who do not prescribe these drugs should not sign up for training as they will not have access to the NovoLogix tool.

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A training video is available on the NovoLogix website, at the NovoLogix Knowledge Base, at **https://www.mycontactual.com/SC/sc_center.php?function=sc_faq&tenant=novologix&sc_name=My%20Default%20Support%20Center***. Please look to the June issue of *The Record* for details on training sessions and registration.

If you have any questions about viewing the training video, please email the NovoLogix Service Helpdesk at helpdesk@novologix.net or call 1-866-480-3971.

For more information on the BCBSM prior authorization requirement, please see the January issue of *The Record*.

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

Michigan Quality Improvement Consortium apps now available

The Michigan Quality Improvement Consortium recently released apps for both iOS (iPhones and iPads) and Android devices. With this capability, you can now access MQIC clinical practice guidelines and physician tools from your smart phone.

The apps are available in the Apple App Store and Google Play for downloading. To access them, enter "MQIC" in the search field.

If you have comments or questions, please call Tracy Zdeb at 313-448-5625 or email her at tzdeb@bcbsm.com.

PROFESSIONAL AND FACILITY

Reminder: Claims must be submitted by filing limits

We will systematically enforce claims filing limits, effective May 24, 2013.

If you submit a claim after your filing limit, Blue Cross Blue Shield of Michigan will not offer any special handling or filing extensions, and no payment will be due from BCBSM or the subscriber.

We've reminded you since April 2012 that it's imperative that you submit your claims on time. As we continue to improve and enhance our claims processing operations, it's critical that you follow submission deadlines for all claims.

Deadline submissions for original claims remain the same – 180 days for professional health care providers and 12 months from the date of service for facility providers. All health care providers must also submit secondary claims, status inquiries and adjustments within 24 months of the date of service.

Note: Secondary, tertiary, dental and all pay-subscriber claims for Federal Employee Program® members must be submitted by Dec. 31 of the year following the original date of service.

Check your BCBSM participation agreement, which defines your time periods for filing claims.

For more information about this requirement, contact your provider consultant.

New facility forms available on upgraded website

New, easier-to-use forms are now available on the upgraded Facility Provider Enrollment website. The forms for **non-hospital** facilities include:

- Facility record update: A combined form for both BCBSM and BCN providers.
- Network agreement and signature documents: Required for facilities wanting to participate in additional networks or new facilities doing business with BCBSM. **Note:** Network approvals are made after credentialing is completed.

To get the forms, **visit bcbsm.com/providers** and follow these steps:

- Under *Join the Blues Network*, click on *Enrollment.*
- Click on *Provider Enrollment.*
- Follow the steps indicated to access the forms for your facility.

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Return the forms to Provider Enrollment via fax at 1-866-900-0250 or mail at:

Provider Enrollment
Blue Cross Blue Shield of Michigan
P.O. Box 217
Southfield MI, 48034

Questions? Call Provider Contracting at 1-800-777-2118.

FACILITY

Reminder: Beginning April 1, use diagnosis code established on date of discharge

As we told you last month, BCBSM has determined that we must change our facility guidelines for reporting diagnosis codes on inpatient claims. Effective April 1, 2013, we are asking our facilities to begin using the diagnosis code set in place on the date of discharge for inpatient claims.

Traditionally, BCBSM guidelines have asked our facilities to report the diagnosis code set on the date of admission.

This change not only meets the mandated requirement for the ICD-10 diagnosis code transition, but it also aligns our billing guidelines with those of other payers and makes us consistent with the Centers for Medicare & Medicaid Services.

Why make the change now?
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. In addition, the extra time allows BCBSM to ensure that our systems will be compliant with the ICD-10 mandate.

Examples of the change
To see how this change will impact you, check the chart below. Keep in mind that the ICD-10 transition date set by CMS is Oct. 1, 2014.

Date of patient discharge	Code set being used by the industry when the patient is discharged	What codes should appear on the inpatient claim
April 1, 2013	ICD-9	ICD-9
Sept. 30, 2014	ICD-9	ICD-9
Oct. 1, 2014, and after	ICD-10	ICD-10

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**.

Outpatient facility services benefit policy changes coming

Effective July 2013, BCBSM plans to make member benefit determinations by processing outpatient facility claims at the HCPCS level, for services that are required to be reported with a HCPCS procedure code.

Currently, benefits are determined at the revenue code level for all hospital outpatient services. Starting in July 2013, when a HCPCS code is not payable based on the group benefits, condition code or occurrence code, the nonpayable service will be rejected and become the member's liability.

We do not anticipate any changes in the way outpatient facilities need to report services.

Look for more detailed articles and updates in upcoming issues of *The Record.*

Reminders: Medical record documentation for physical and occupational therapy

In conducting audits, we've found that the medical record documentation we receive from hospitals and physical therapy facilities for outpatient services isn't always complete or legible.

Here are some important reminders to ensure that the information you submit is in compliance with BCBSM documentation guidelines for physical therapy and occupational therapy services:

Documentation must be legible. If we can't read it, we can't decide whether the services billed to BCBSM were appropriate. Keep in mind that the signature and credentials of the therapist providing the services must also be legible.

The physician orders (for the initial 30 days and any subsequent months of the treatment period) must include the following:

- Date of the order
- Diagnoses
- Frequency of treatment
- Specific duration of treatment
- Type and focus of treatment (modalities) to be provided
- Physician signature date (We will accept a legible fax date.)

For a list of the complete requirements, refer to the "Documentation Guidelines" chapter of your BCBSM provider manual. (See box at end of article.)

For continuing physician orders (renewed plan of care), include the dates of service for which the 30-day continuation is requested (e.g., the recertification period). This allows us to determine whether the physician has signed it in a timely manner. As long as the physician signs it within the recertification period, the order is considered valid and timely. If there is no specified date range, then the date of the physician's signature becomes the new starting date of the 30-day coverage period.

Physician orders must be signed and dated within the 30-day treatment period. If it is signed and dated outside of this period, it will not be considered valid.

Physician orders are only valid for 30 days. Even if the physician orders therapy services for more than 30 days, the order will only be considered valid for 30 days.

Documentation of each treatment session billed to BCBSM (daily progress note or flow chart) must include the patient's response to treatment. For a list of the complete requirements, refer to the "Documentation Guidelines" chapter of your BCBSM provider manual.

The monthly progress summary must be documented in the medical record at least once every 30 days to summarize the patient's response to treatment. The monthly progress summary also can be used to meet the physician communication requirement, which specifies that the physician and therapist must communicate with each other about the patient's progress every 12 visits or 30 days. In addition, the summary can be used as a subsequent physician order for continuing services, as long as the other necessary requirements are met. The summary should measure progress achieved and any resetting of goals for future achievement.

Monthly progress summaries must be authored by the therapist. Therapy assistants may contribute to the monthly progress summaries by documenting data collection or by providing information other than patient assessments.

The evaluation documentation must include statements of the goals established for the patient:

- For occupational therapy services, this includes documentation of reasonable functional activities of daily living short- and long-term goals.
- For physical therapy services, this includes documentation of treatment goals (therapeutic goals that are appropriate for the patient, the diagnoses, rehabilitation potential and the treatment to be provided).

Documentation of the therapy evaluation must include the functional level prior to the onset of the current illness, injury or exacerbation. This will provide the information to determine whether services are appropriate and medically necessary.

When preparing for an audit appointment, remember to provide the documentation for the entire treatment episode. If only one or two months of the treatment episode were selected for the audit sample, we still will want to review the entire record in order to gain a complete understanding of the patient's response to treatment.

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Note: These reminders are not intended to override any published BCBSM guidelines.

If you have questions about the information in this article, call Debra Amross, Utilization Review, at 313-448-1284 or send her an email at damross@bcbsm.com.

Documentation guidelines
To access the BCBSM provider manual chapter titled "Documentation Guidelines for Physicians and Other Professional Providers," follow these steps:

- From the home page of web-DENIS, click on *BCBSM Provider Publications and Resources* in the left-hand column.
- Click on *Provider Manual.*
- Click on *Provider Type* and make a selection from the drop-down menu.
- Click the *Search* button and scroll down to "Documentation Guidelines for Physicians and Other Professional Providers."

Precertify detox treatment for State of Michigan employees

Acute care hospitals must submit a precertification request when admitting State of Michigan employees for substance abuse detoxification treatment (including alcohol withdrawal).

Please follow this process:

1. Determine if the patient is a State of Michigan employee (BCBSM group number 007000562).
2. If the patient is a State of Michigan employee, fill out the *Acute Inpatient Fax Assessment Form* located at **bcbsm.com/providers/quick-links.html**.
3. Fax the form to 1-866-411-2585 or email it to acuteprecertification1@bcbsm.com.

Please remember that if the incoming patient is **not** a State of Michigan employee, please call Magellan Behavioral at 1-800-762-2382 for precertification.

If you have questions, please contact your provider consultant.

Southeast Michigan facility training sessions scheduled

To make sure you have the tools and resources you need to do business with the Blues, we've scheduled facility training sessions for 2013.

The classes will give an overview of the billing procedures and guidelines for your specific facility, and provide an overview of web-DENIS features that will assist you with navigation. In addition, we'll clarify any upcoming policy and benefits changes that will affect your facility.

Here's more information about the sessions:

- All classes will be at Lyon Meadows, 53200 Grand River Ave., New Hudson, Michigan.
- Morning classes will start at 9 a.m., with registration beginning at 8:30 a.m.
- Afternoon classes will start at 1 p.m., with registration beginning at 12:30 p.m.
- Classes might extend later or end earlier, depending on participant questions.
- There will be no refreshments served at classes. However, there are vending machines and a cafeteria on site.
- These classes do not offer continuing education units and do not include clinically specific subject matter.
- You will not need any additional reference materials or manuals.

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Here's a list of the upcoming sessions:

Non-hospital consultants	Provider type	Spring date	Fall date
Kimberly J. Wray-Norman	Home Health Care	• Thursday, May 16, 2013 • Morning session • Lyon Meadows Cobalt - Conference Room C	• Thursday, Nov. 14, 2013 • Morning session • Lyon Meadows Teal - Conference Room K
Wanza Martin	Physical Therapy (occupational, physical and speech therapy)	• Thursday, May 16, 2013 • Afternoon session • Lyon Meadows Cobalt - Conference Room C	• Thursday, Nov. 14, 2013 • Afternoon session • Lyon Meadows Teal - Conference Room K
Christina Frison	Outpatient Psychiatric Care	• Thursday, June 6, 2013 • Morning session • Lyon Meadows Teal – Conference Room K	• Tuesday, Oct. 22, 2013 • Morning session • Lyon Meadows Teal – Conference Room K
Ava Shephard	Skilled Nursing Facility	• Wednesday, April 24, 2013 • Morning session • Lyon Meadows Cobalt Conference Room C	• Wednesday, Oct. 23, 2013 • Morning session • Lyon Meadows Teal Conference Room K
Corinne Vignali	Substance Abuse	• Wednesday, April 24, 2013 • Afternoon session • Lyon Meadows Cobalt Conference Room C	• Wednesday, Oct. 23, 2013 • Afternoon session • Lyon Meadows Teal Conference Room K

To register, email SEfacilityeducationregistration@bcbsm.com and indicate the name and time of the class you wish to attend. You'll receive a confirmation within 72 hours of registering. It's important to register so that we may contact you in the event that a session changes or is cancelled.

If you would like to discuss specific questions at the session, contact your facility provider consultant. Please note that we will not accept claim-specific questions at the sessions.

Register today for annual hospital forum in Frankenmuth

The Blues invite you to the annual hospital forum sponsored by the Benefit Administration Committee. This year's forum is scheduled for Wednesday, May 1, 2013, for all hospital billing staff, managers and directors.

The event includes information on web-DENIS, ICD-10, BlueCard®, Medicare Advantage and the Federal Employee Program®. The forum starts with an information fair during registration, followed by classroom-style presentations on a variety of important topics. A lunch featuring Frankenmuth's famous chicken will be served following the event.

Where: Bavarian Inn Lodge
1 Covered Bridge Lane
Frankenmuth, Michigan
1-888-775-6343

Who: All hospital billing managers, directors and staff

Schedule: Registration and information fair: 8:15 a.m.
Program: 9 a.m.
Lunch: 12 p.m.

RSVP to jholzhausen@bcbsm.com by Friday, April 26. In the subject line, indicate "BAC Forum" and list your name, facility and the total number of people attending from your facility. Your response is also an RSVP for lunch.

If you have other agenda topic suggestions, please include them in your email, and we'll attempt to address them at the forum.

Providers to get new message for daily quantity maximums

Starting as early as this June, providers will receive a new message when a submitted HCPCS or CPT procedure code reaches or exceeds its recommended daily quantity maximum.

This maximum determines the number of times a procedure can be billed on a single claim line for a particular date. Currently, there is no outpatient facility message when this daily maximum is reached or exceeded.

When a maximum quantity is reached, this message will alert providers that they only will be reimbursed for the daily maximum quantity. For example, if the maximum is five per day for a reported HCPCS or CPT code, but 15 are submitted, the message will state that there's been an adjustment in the reimbursement. Payment will be made for the first five only.

Web-DENIS will display claims information with both the paid and maximum quantities.

Blue Preferred Plus^{SM} referral process changes

Blue Preferred Plus practitioners referring members to out-of-network physicians will no longer be required to call BCBSM Medical Care Management Operations for referral authorizations. Practitioners may now complete a new Blue Preferred Plus referral form without obtaining approval.

Blue Preferred Plus members must receive non-emergency services from affiliated Blue Preferred Plus physicians within the Blue Preferred Plus 21 counties in Central, East and Southeast Michigan.

Southeast Michigan counties	Mid-Michigan counties	East Michigan counties
Macomb	Clinton	Arenac
Monroe	Eaton	Bay
Oakland	Ingham	Genesee
St. Clair	Jackson	Gratiot
Washtenaw	Livingston	Isabella
Wayne		Lapeer
		Midland
		Saginaw
		Shiawassee
		Tuscola

Outside of the 21 counties, Blue Preferred Plus members may see physicians in the TRUST PPO network. TRUST physicians may refer patients to non-network doctors using the BCBSM TRUST PPO referral process. You may refer patients to a specialist who is not in the network if there is no network specialist within 20 miles of the member's home.

Blue Preferred Plus referral process

1. Blue Preferred Plus network physicians must complete the new *Blue Preferred Plus Program Referral Form* before members receive services from the non-network physician.
2. The BPP program referral form is available in two formats:
   - You can order a supply of the printed, triplicate form, form number 13059. For order information, see the *Blues Pages* directory in your online provider manual.
   - You can access and print the electronic form from our website, at **bcbsm.com**:
     - Click on *Providers*.
     - Click on *Help* and select *Plan Documents and Forms*.
     - Scroll down and click on *Referrals*.
     - Click on the *Blue Preferred Plus Program Referral Form*.

       You will need three copies — one for each of the following: Blue Preferred Plus referring provider, the referred-to provider and the member.
3. Referrals are only valid up to 60 days after the date the BPP network physician completes the referral form. Retrospective referrals will not be approved without documentation of the patient's medical record indicating referral was prior to the member receiving services from the non-network practitioner.
4. The completed referral may cover services up to one year.
5. The non-Blue Preferred Plus network physician should complete the referral form and return a copy to the BPP network referring physician.
6. The signatures of the BPP network referring physician, non-network physician and member must be on the *Blue Preferred Plus Program Referral Form*.
7. The BPP network referring physician, non-network physician and member must retain copies of the completed and signed referral form.

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Submitting claims on the CMS-1500 claim

1. The referring BPP network physician's seven-digit PIN must be in Field 10d and the 10-digit NPI in Field 17b of the CMS-1500 claim from the non-BPP network physician.
2. The CMS-1500 claim should be submitted with a copy of the referral form attached. If the non-network physician bills electronically, he or she should keep a copy of the referral form in the member's medical record.
3. If the BPP network referring physician's seven-digit PIN is not on the CMS-1500 claim or if the referral services are not requested by a BPP network referring physician, the services could be subject to out-of-network costs.

Submitting claims on the UB-04 claim

1. The referring BPP network physician's seven-digit PIN must be in Form Locator 63, Treatment Authorization, and the 10-digit NPI in Form Locator 56 of the UB-04 claim from the non-network physician. The UB-04 claim should be submitted with a copy of the referral form attached. If the non network physician bills electronically, he or she should keep a copy of the referral form in the member's medical record.
2. If the BPP network referring physician's seven-digit PIN is not on the UB-04 claim or if the referral services are not requested by a BPP network referring physician, the services could be subject to out-of-network penalties.

HCPCS codes added, deleted

The Centers for Medicare & Medicaid Services has added 16 new HCPCS codes and one modifier, and deleted three codes as part of its regular quarterly HCPCS updates.

The new codes are listed below.

Code*	Change	Coverage Comments	Effective Date
0004M	Added	Not covered by BCBSM	July 1, 2013
0005M	Added	Covered by BCBSM	July 1, 2013
0329T	Added	Not covered by BCBSM	July 1, 2013
0330T	Added	Not covered by BCBSM	July 1, 2013
0331T	Added	Not covered by BCBSM	July 1, 2013
0332T	Added	Not covered by BCBSM	July 1, 2013
0333T	Added	Not covered by BCBSM	July 1, 2013
0334T	Added	Not covered by BCBSM	July 1, 2013
C9130	Added	Not covered by BCBSM	April 1, 2013
C9297	Added	Not covered by BCBSM	April 1, 2013
C9298	Added	Not covered by BCBSM	April 1, 2013
C9734	Added	Not covered by BCBSM	April 1, 2013
C9735	Added	Not covered by BCBSM	April 1, 2013
Q0507	Added	Requires manual review	April 1, 2013
Q0508	Added	Requires manual review	April 1, 2013
Q0509	Added	Requires manual review	April 1, 2013
33	Added	Informational only	Jan. 1, 2011

The deleted codes are listed below.

Code*	Change	Effective Date
Q0505	Deleted	March 31, 2013
90470	Deleted	Dec. 31, 2010
90663	Deleted	Dec. 31, 2010

Patients can dispose of unwanted medications on Drug Take-Back Day

Your patients can safely dispose of unwanted prescription drugs during the next National Prescription Drug Take-Back Day on Saturday, April 27, from 10 a.m. to 2 p.m.

Just in time for spring cleaning, the Drug Enforcement Administration will work with state and local law enforcement agencies across the country to help people get rid of any expired or unwanted prescription drugs.

Since the first take-back event, the DEA and its state, local and tribal law enforcement partners have collected more than 2 million pounds (1,018 tons) of prescription medications. To learn more about these efforts, or to find local collection sites, visit the DEA website at **dea.gov***.

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

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	
E1161, E1229, E1231-E1238, K0001-K0007, K0009	**Inclusionary Guidelines** A manual wheelchair for use inside the home (E1161, K0001 – K0007, K0009) is covered if both of the following are true: • Criteria A, B, C, D and E are met. • Criterion F or G is met. A. The member has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living such as toileting, feeding, dressing, grooming and bathing in customary locations in the home. **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES

E1161, E1229, E1231-E1238, K0001-K0007, K0009

Continued

A mobility limitation is one that does one of the following:

1. Prevents the member from accomplishing an MRADL entirely
2. Places the member at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL
3. Prevents the member from completing an MRADL within a reasonable time frame

B. The member's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.

C. The member's home provides adequate access between rooms, maneuvering space and surfaces for use of the manual wheelchair that is provided.

D. Use of a manual wheelchair will significantly improve the member's ability to participate in MRADLs, and the member will use it on a regular basis in the home.

E. The member has not expressed an unwillingness to use the manual wheelchair that is provided in the home.

F. The member has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion or coordination, presence of pain or deformity, or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

G. The member has a caregiver who is available, willing and able to provide assistance with the wheelchair.

If the manual wheelchair will be used inside the home and the coverage criteria are not met, it will be denied as not reasonable and necessary.

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UPDATES TO PAYABLE PROCEDURES	
E1161, E1229, E1231-E1238, K0001-K0007, K0009 ***Continued***	If the manual wheelchair will only be used outside the home, see the related policy article for information concerning coverage. **Additional criteria for specific manual wheelchairs (K0002 – K0007)** In addition to the general manual wheelchair criteria above, the specific criteria below must be met for each manual wheelchair. A standard hemi-wheelchair (K0002) is covered when the member requires a lower seat height (17 to 18 inches) because of short stature or to enable the member to place his or her feet on the ground for propulsion. A lightweight wheelchair (K0003) is covered when a member meets both criteria: 1. Cannot self-propel in a standard wheelchair in the home 2. The member can and does self-propel in a lightweight wheelchair. A high-strength lightweight wheelchair (K0004) is covered when a member meets one of the criteria below: 1. The member self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair. 2. The member requires a seat width, depth or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair. A high-strength lightweight wheelchair is rarely reasonable and necessary if the expected duration of need is less than three months (for example, post-operative recovery). An ultra-lightweight manual wheelchair (K0005) is covered for a member who meets all of the following criteria: 1. The member must be a highly active, full-time manual wheelchair user. 2. The member must require individualized fitting and optimal adjustments for multiple features that include axle configuration, wheel camber and seat and back angles, in addition to ongoing critical support. **Continued on next page**

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BENEFIT POLICY continued from Page 14

UPDATES TO PAYABLE PROCEDURES	
E1161, E1229, E1231-E1238, K0001-K0007, K0009 ***Continued***	3. The member must have a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist or occupational therapist, or physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the medical necessity for the wheelchair and its special features. (See documentation requirements.) The medical professional may have no financial relationship with the supplier. 4. The wheelchair is provided by a rehabilitative technology supplier that employs a RESNA-certified assistive technology professional who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the patient A heavy-duty wheelchair (K0006) is covered if the member weighs more than 250 pounds or the member has severe spasticity. An extra heavy-duty wheelchair (K0007) is covered if the member weighs more than 300 pounds. If a K0002–K0007 wheelchair is provided and the additional coverage criteria are not met, it will be denied as not reasonable and necessary. **Miscellaneous** Payment is made for only one wheelchair at a time. Backup chairs are denied as not reasonable and necessary. One month's rental for a standard manual wheelchair (K0001) is covered if a member-owned wheelchair is being repaired.
GROUP BENEFIT CHANGES	
Burris Logistics	Effective April 1, 2013, Medicare-eligible retirees of Burris Logistics will have Blue Cross Blue Shield of Michigan's Medicare Advantage prescription drug plan, Prescription Blue℠, for their prescription drug benefits. The group number is 60048 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 plans, go to **bcbsm.com/provider/ma**.
Charter Township of Waterford	Effective April 1, 2013, Medicare-eligible retirees of the Charter Township of Waterford will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical and surgical benefits. The group number is 60027 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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GROUP BENEFIT CHANGES	
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**.
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**.
Saginaw Chippewa Indian Tribe	Effective April 1, 2013, Medicare-eligible retirees of the Saginaw Chippewa Indian Tribe will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical and surgical benefits. The group number is 59937 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**.
SEIU Healthcare	Effective April 1, 2013, Medicare-eligible retirees of SEIU Healthcare 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 60100 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 continued from Page 16

GROUP BENEFIT CHANGES	
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**.

Blues committed to quality service for MIChild program

Assessment and Performance Improvement Program plan.

As part of this plan, goals and objectives are set and then implemented throughout the year to improve the quality of services. Current goals include maintaining immunization and well-child visit rates, while objectives include providing health care education and evaluating member satisfaction.

For more information on the Blues' MIChild Quality Improvement Program and Outcomes, contact your provider consultant.

Regular patient updates critical to MIChild program

Up-to-date patient immunization history is an important part of the health care process. Given the national focus on health care, continually updating immunization records for children insured through the MIChild program is important.

Please ensure MIChild member information is regularly updated through the Michigan Care Improvement Registry at **micr.org***.

The Blues thank you for helping keep Michigan's children healthy and strong.

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ALL PROVIDERS

Subscribe to *BCN Provider News* to read new series on patient satisfaction

Even if you provide the best quality care, sometimes it's the little extras that make patients happy. In a new series of articles on patient satisfaction, *BCN Provider News* interviews physicians who increase patient compliance by sharing decision-making about treatment options, communicating effectively with patients and coordinating care with specialists.

We know you already provide high-quality care. We are focused on helping you build a better practice and increase patient satisfaction with your practice and the Blues.

See the March-April issue, Page 32, to read about how patient communication helps patients get involved in their care.

When you subscribe to *BCN Provider News*, you can also check out important information about billing and claims, referral requirements, clinical practice guidelines and chronic condition management programs.

To subscribe, go to the *BCN Provider News* page, click on "Subscribe," and check the box next to *BCN Provider News and BCN Alerts*. The e-mail notification you receive will contain headlines specifically of interest to you if you select a BCN topic of interest when you subscribe.

DME

DME, P&O fee revisions available on web-DENIS

BCBSM has revised the fee schedule for durable medical equipment and prosthetic and orthotic items. The revisions will be effective July 1, 2013.

The fees for DME and P&O items, as well as all of our fee schedules, are available on web-DENIS:

- Click on *BCBSM Provider Publications and Resources*.
- Click on *Entire Fee Schedules and Fee Changes*.

Try our online tools

Check out the Blues' secure website for participating health care providers, if you're not already using it. Provider Secured Services gives you online information to make your job easier.

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Contact Us

Provider Consulting Services, Manager's Office

Southeast Michigan	313-225-7778 (professional) 313-225-0914 (facilities)
West Michigan	616-389-8141
Mid Michigan	517-325-4590
Upper Peninsula	906-228-5457

Provider Contracting (facility)

1-800-777-2118

providercontracting@bcbsm.com

Provider Enrollment and Data management (professional)

1-800-822-2761

Physician Ombudsman office

1-800-816-BLUE (2583)

Other valuable contact information

DRAMS (Pharmacy)	1-800-437-3803
Dental Network of America	1-888-826-8152
Blue Care Network	1-800-255-1690
Blue Choice® Point of Service	1-877-285-0172
BlueCard®	1-800-676-2583
Michigan State Medical Society	517-337-1351
Michigan Osteopathic Association	517-347-1555
Michigan Health & Hospital Association	517-323-3443
Web-DENIS	1-877-258-3932

Electronic Claims Submission

Electronic data interchange	1-800-542-0945, prompt 4

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A provider publication produced by the Corporate Communications department 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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