May 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 May issue on April 30.

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**:

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

Remember to correctly report diagnosis codes

Appropriate diagnosis coding plays a critical role in accurately describing a patient's condition, underlying conditions and any complicating factors. Here are some key points to keep in mind.

Why is appropriate coding important?
Appropriate coding helps to:

- Ensure appropriate benefit application and payment
- Provide patients with the best care management
- Give an accurate picture of a patient's overall health
- Reduce on-site reviews

In addition, it will help you as we move into the future. As you may already know, there is a call for increased detail in medical records and appropriate diagnostic coding for things like:

- Quality measures
- Government programs
- Incentive programs (from the Centers for Medicare & Medicaid and from other payers)

Medical records: an essential part of the process
Appropriate coding depends in large part on the information and details included in a patient's medical record. Here are some important things to keep in mind about medical records:

- Document all of a patient's existing health conditions. (All chronic conditions must be documented and reported at least once a year.)
- Medical records must support a treated or addressed condition and be signed, credentialed and dated by the physician.
- Documentation in the medical record must provide specific information about the diagnoses.
- Include supporting documentation about all chronic conditions.
- Conditions must follow the M.E.A.T. documentation guidelines in the medical record, indicating that the condition was:
  - **M**anaged
  - **E**valuated
  - **A**ssessed
  - **T**reated
- The medical record is the only source of truth.

Stay tuned: Training classes, articles in *The Record*
Over the next few months, you'll have the chance to learn more about appropriate coding through training classes and *Record* articles. We've set up several coding-focused webinars and training sessions. See "Updated training schedule for 2013" on Page 14, and "Blues offer webinars for professional coding services" on Page 10, for more information.

You'll also want to check out the coding tips article below.

Keep in mind these coding tips to improve medical record documentation

ICD-9-CM diagnosis codes, along with Current Procedural Terminology codes reported on claims, must be supported by documentation in a patient's medical record.

ICD-9-CM is the national standard coding language used to translate a patient's clinical condition into three- to five-digit codes.

Accurate coding starts with accurate documentation
Clear and concise documentation is essential to providing the best quality of care to patients and ensures health care providers receive their payments in a timely manner.

When documentation standards are met and maintained, there shouldn't be concern about any impending audit or review.

Some of the most challenging conditions to code are diseases of the vascular system. This includes venous thromboembolism and peripheral vascular disease.

Documentation and coding tips for vascular diseases

- Venous thromboembolism is a disease that includes both deep vein thrombosis and pulmonary embolism.

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- There are specific ICD-9-CM codes to indicate the vessel involved and specific codes to indicate whether the condition is acute or chronic. Make sure you're specific when you document and code the blood vessel that's affected and whether it's acute or chronic for both venous thromboembolism and pulmonary embolism.
- For deep vein thrombosis, when the documentation does not specify the vessel affected or the status of the condition, then it's coded as 453.40-DVT NOS (not otherwise specified).
- There's no specific timeframe that differentiates an acute pulmonary embolism from a chronic pulmonary embolism. The differentiation is determined by the provider's documentation. In most patients with pulmonary embolism, the emboli dissolve. However, in a small group of patients, the emboli persist and a state of chronic pulmonary embolism develops.
- If the provider documents "history of deep vein thrombosis" or "history of pulmonary embolism," then the codes are V12.51 and V12.55, respectively. A history of V code means that the condition **no longer exists**.
- Aortic atherosclerosis and peripheral atherosclerosis are chronic conditions that should be assessed, documented and coded each year.
- If known, document and code the cause of the peripheral artery disease as well as the complication. For example, "lower leg ulcer due to peripheral artery disease."
- Unspecified peripheral vascular disease, peripheral artery disease or intermittent claudication are coded with 443.9 (Peripheral vascular disease, unspecified). Please note that there are more specific codes to indicate the area and the condition of the atherosclerosis.

Common vascular conditions	ICD-9-CM
Aortic atherosclerosis	440.0
Atherosclerosis of native arteries of the extremities	440.2X
Acute deep vein thrombosis (initial episode of care)	453.4X
Chronic deep vein thrombosis	453.5X
Acute pulmonary embolus	415.19
Chronic pulmonary embolus	416.2

Please review the ICD-9-CM coding manual for the fourth- and fifth-digit codes for specifics on code selection.

HEDIS specifications for LDL-C medical record documentation have changed

The 2013 Healthcare Effectiveness Data and Information Set® specifications for LDL-Cs have changed for *Cholesterol Management for Patients with Cardiovascular Conditions* and *Comprehensive Diabetes Care*.

This includes Blue Cross Blue Shield of Michigan and Blue Care Network Health e-Blue entries and data received from electronic medical records and disease management registries, as well as paper medical records.

Following are the 2013 documentation requirements for LDL-C medical records:

- At a minimum, include in the medical record a note indicating the date when the LDL-C test was performed and the result.
- Calculate LDL-C levels from total cholesterol, HDL-C and triglycerides, using the Friedewald equation if the triglycerides are less than or equal to 400 mg/dL. For example:

  LDL-C = total cholesterol – HDL – triglycerides/5
- If measuring lipoprotein (a), use the following calculation:

  LDL-C = total cholesterol – HDL – triglycerides/ 5 – 0.3 [lipoprotein (a)]

These formulas are used when all levels are expressed in mg/dL and cannot be used if triglycerides are greater than 400 mg/dL. Do not use the Friedewald equation if a direct or calculated result is present in the medical record for the most recent LDL-C test.

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

Important reminder: Submit claims on time

It's critical that you follow submission deadlines for all claims. Starting May 24, 2013, filing limits will be strictly enforced.

If you submit a claim after your filing limits, 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. If you haven't submitted a claim because you're having difficulty identifying a member's contract number, log in to web-DENIS and use the Subscriber Name Search feature.

Deadline submissions for original claims remain the same — 180 days from the date of service for professional providers and 12 months from the date of service for facility providers. If you're submitting a Master Medical claim that will be paid to the subscriber, the filing limit will be two years. Claims for dates of service prior to the contract migrating to MOS are pay-subscriber, after MOS migration, the provider is paid and regular filing limits apply.

Health care providers must also submit secondary claims, status inquiries and adjustments within 24 months of the date of service.

Please note that 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.

This information is included in your BCBSM participation agreement.

For more information about this requirement, see the related article in the April 2013 issue of *The Record* or contact your provider consultant.

Blues now send Master Medical reimbursement directly to providers

When processing a claim for a member with Master Medical coverage, Blue Cross Blue Shield of Michigan will pay the participating provider its approved amount, less the patient's copayment, coinsurance and deductible for medically necessary covered services.

As with our other coverage plans, you've agreed to accept our approved amount as payment in full for covered Master Medical services.

We recently transferred all of the Master Medical groups to our Michigan Operating System. The move to MOS helped us align our Master Medical reimbursement process with our other coverage plans. Prior to the transfer, we sent Master Medical reimbursements directly to the patient, and you were responsible for collecting the payment. Under this newer, simpler reimbursement process, you should no longer be collecting payments from patients, except for normal cost-sharing amounts (deductibles, copayments and coinsurance).

The claims filing limit for submitting a Master Medical claim is two years, so you may still have some pay-subscriber claims during that time period. Claims for dates of service prior to the contract migrating to MOS are pay-subscriber. After MOS migration, health care providers are paid directly and regular filing limits apply. (See the article above.)

Remember: Master Medical benefits have not changed, just the way we process reimbursements has.

For more information, contact your provider consultant.

Hospital-based practitioners encouraged to keep CAQH information current

Blue Cross Blue Shield of Michigan and Blue Care Network's enrollment and credentialing system is programmed to be consistent with the Council for Affordable Quality Healthcare database.

That's why it's so important to keep your information updated on CAQH, which serves as our official application and is used to update our systems. In order to maintain data accuracy, practitioners who do not keep up their CAQH attestation are not listed in the directory. CAQH requires application reattestation every 120 days, regardless of whether you are practicing at an office location or practicing exclusively in an inpatient hospital setting.

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If you are practicing exclusively in an inpatient hospital setting, be sure you have indicated this on your CAQH application, as this information is used to determine whether full credentialing is required.

If you have any questions about CAQH or the credentialing process, refer to the CAQH website at **caqh.org***, contact the CAQH help desk at 1-888-599-1771 or call your BCBSM or BCN provider representative.

*BCBSM does not control this website.

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**
NEW PAYABLE PROCEDURES	
J3490	**Basic Benefit and Medical Policy** The Food and Drug Administration approved Skyla, Levonorgestrel-releasing intrauterine device system, effective Jan. 9, 2013. Skyla 13.5 mg is a hormone-releasing system placed in the uterus to prevent pregnancy for up to three years. It is now payable under the medical and surgical benefits for contracts that cover contraceptive services. It should be considered payable for all FDA-approved indications. Until June 30, 2013, when billing Skyla, please report procedure code J3490, unclassified drugs. Please remember to submit your claims with the National Drug Code and supporting documentation required for unclassified procedures. Effective July 1, 2013, please use the established code for Skyla, Q0090.

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BENEFIT POLICY continued from Page 5

NEW PAYABLE PROCEDURES	
20974, 20975, E0748, E0749	**Basic Benefit and Medical Policy** The safety and effectiveness of invasive or noninvasive methods of electrical bone growth stimulation of the spine have been established. They are useful therapeutic options for patients meeting selection criteria. **Inclusionary Guidelines** Invasive or noninvasive methods of electrical bone growth stimulation are appropriate for use as an **adjunct** to lumbar or cervical spinal fusion surgery in patients at high risk for fusion failure, defined as any one of the following criteria: • One or more previous failed spinal fusion(s) • Grade III or worse spondylolisthesis • Fusion to be performed at more than one level • Current tobacco use • Diabetes • Renal disease • Alcoholism • Steroid use Noninvasive electrical bone stimulation may be considered medically necessary as a treatment for patients with failed lumbar or cervical spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial X-rays over a course of three months. **Exclusionary Guidelines** Semi-invasive electrical stimulation.
55706, G0417-G0419	**Basic Benefit and Medical Policy** The safety and effectiveness of saturation biopsy (taking more than 20 samples) of the prostate have been established. It is a useful therapeutic option for patients meeting appropriate patient selection criteria, effective May 1, 2013. **Inclusionary Guidelines** Saturation biopsy of the prostate is considered established for the following indications in men with at least **two** prior extended transrectal prostate biopsies that are negative for invasive cancer and one of the following: • Elevated prostate specific antigen that is persistently rising • Men with histologic evidence of atypia on prior prostate biopsy • Men with histologic findings of high-grade prostatic intraepithelial neoplasia on a prior biopsy **Note**: PSA values should be reported from the **same** laboratory, as techniques for measuring these values may vary from lab to lab. **Exclusionary Guidelines** Men not meeting the above criteria.

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UPDATES TO PAYABLE PROCEDURES

88299, S3854	**Basic Benefit and Medical Policy** The safety and effectiveness of the use of the 21-gene reverse transcriptase-polymerase chain reaction (RT-PCR) assay (Oncotype DX®) have been established. It is a useful diagnostic test for determining the likelihood of distant cancer recurrence in women for patients who meet the selection criteria. Other genetic testing for determining the likelihood of distant cancer recurrence in women is considered experimental. This policy update is effective May 1, 2013. **Inclusionary Guidelines** The use of Oncotype DX to determine recurrence risk for deciding whether or not to undergo adjuvant chemotherapy may be considered established in women with breast cancer meeting **all** of the following characteristics: • Unilateral, non-fixed tumor • Hormone receptor positive (that is estrogen-receptive positive or progesterone-receptor positive) • Human epidermal growth factor receptor 2 negative • Tumor size 0.6-1 cm with moderate or poor differentiation or unfavorable features, **or** tumor size larger than 1 cm • Node negative (lymph nodes with micrometastases [less than 2 mm in size] are considered node negative) • Women who will be treated with adjuvant endocrine therapy, such as tamoxifen or aromatase inhibitors • When the test result will aid the patient in making the decision regarding chemotherapy (when chemotherapy is a therapeutic option) • When ordered within six months following diagnosis, since the value of the test for making decisions regarding delayed chemotherapy is unknown The 21-gene RT-PCR assay Oncotype DX should only be ordered on a tissue specimen obtained during surgical removal of the tumor and after subsequent pathology examination of the tumor has been completed and determined to meet the above criteria. (The test should not be ordered on a preliminary core biopsy.) The test should be ordered in the context of a physician-patient discussion regarding risk preferences when the test result will aid in making decisions regarding chemotherapy. **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
88299, S3854 ***Continued***	For patients who otherwise meet the above characteristics but who have multiple ipsilateral primary tumors, a specimen from the tumor with the most aggressive histological characteristics should be submitted for testing. It is not necessary to conduct testing on each tumor; treatment is based on the most aggressive lesion. **Exclusionary Guidelines** • All other indications for the 21-gene RT-PCR assay, including determination of recurrence risk in invasive breast cancer patients with **positive** lymph nodes or patients with **bilateral** disease, are considered experimental. • Use of a subset of genes from the 21-gene RT-PCR assay for predicting recurrence risk in patients with noninvasive ductal carcinoma in situ to inform treatment planning following excisional surgery is considered experimental. • The use of other gene expression assays (for example, MammaPrint 70-gene signature, Mammostrat Breast Cancer Test, the Breast Cancer Index, the BreastOncPx, NexCourse Breast IHC4 or PAM50 Breast Cancer Intrinsic Classifier) for **any** indication is considered experimental.
EXPERIMENTAL PROCEDURES	
76498	**Basic Benefit and Medical Policy** Magnetic resonance neurography is considered experimental. Its use has not been scientifically demonstrated to improve patient clinical outcomes, effective May 1, 2013.
82777	**Basic Benefit and Medical Policy** Galectin-3 testing is considered experimental, effective May 1, 2013. The peer-reviewed medical literature has not yet demonstrated the clinical utility of this test for the assessment and management of patients with heart failure.
GROUP BENEFIT CHANGES	
AG Simpson Michigan, Inc.	Effective May 1, 2013, Medicare-eligible retirees of AG Simpson Michigan, 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 60143 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.**
City of Lathrup Village	Effective May 1, 2013, Medicare-eligible retirees of the City of Lathrup Village will have Blue Cross Blue Shield of Michigan's Medicare Advantage prescription drug plan, Prescription Blue PDP℠, for their prescription drug benefits. **Continued on next page**

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GROUP BENEFIT CHANGES	
City of Lathrup Village ***Continued***	The group number is 60114 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**.
City of Taylor	Effective May 1, 2013, Medicare-eligible retirees of the City of Taylor will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠. There are five options: Four options that include coverage for their medical, surgical and prescription drug benefits and one MA PPO only option for their medical and surgical benefits. The **MA PPO option** has a group number of 59819 with suffix 600. The **MAPD option** has a group number of 59819 with suffixes 601, 602, 603 and 604. 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**.
Decker Manufacturing	Effective May 1, 2013, Medicare-eligible retirees of Decker Manufacturing 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 60153 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**.
Globe Midwest	Effective May 1, 2013, Medicare-eligible retirees of Globe Midwest 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 60211 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**.
Huron Charter Township	Effective May 1, 2013, Medicare-eligible retirees of Huron Charter Township 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 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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ALL PROVIDERS

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GROUP BENEFIT CHANGES	
Kaydon Corporation	Kaydon Corporation, group number 71504, is adding 100 new employees to BCBSM and new package codes 064, 065, 066 and 068, effective May 1, 2013. The group offers three PPO plans with medical-surgical coverage and one dental plan. Member ID cards will show alpha prefix KYD for PPO coverage.

PROFESSIONAL

PGIP accepting applications from new organized systems of care through June 30

The Physician Group Incentive Program will accept applications from newly formed organized systems of care starting May 1 through June 30. OSCs whose applications are approved will become PGIP-contracted OSCs effective Nov. 1, 2013.

Participation in the PGIP OSC program gives organizations an opportunity to partner with PGIP on initiatives and earn PGIP financial rewards.

PGIP OSC initiatives are part of a shift to population-management activities. Other activities like this include BCBSM's hospital infrastructure agreements and value-based contracting.

It is all part of BCBSM's efforts to help our provider partners transform health care. Organizations that are in the PGIP OSC program may participate in efforts to build OSC infrastructure and integrated processes of care.

To receive the OSC application packet, please email or contact Donna Saxton at dsaxton@bcbsm.com or 313-448-0969.

Please note: OSCs currently contracted with PGIP should not submit a new application.

Blues offer webinars on professional coding services

Blue Cross Blue Shield of Michigan is offering a series of webinars throughout 2013 to support the new BCBSM coding initiative and computer-based training that was recently released on web-DENIS.

We encourage you view the training opportunities on web-DENIS and join one of the webinars listed below.

The webinars will cover the information in the computer-based training sessions and allow the opportunity-ask questions of certified coders.

Here are webinars that BCBSM is hosting throughout 2013:

Date	Time
Tuesday, April 30	12-1 p.m.
Thursday, May 9	12-1 p.m.
Wednesday, May 15	9-10 a.m.
Wednesday, May 22	9-10 a.m.
Wednesday, May 29	12-1 p.m.
Wednesday, June 5	9-10 a.m.
Wednesday, June 12	12-1 p.m.
Thursday, June 20	9-10 a.m.

Date	Time
Tuesday, June 25	12-1 p.m.
Wednesday, July 10	9-10 a.m.
Wednesday, July 17	9-10 a.m.
Wednesday, July 24	9-10 a.m.
Wednesday, July 31	9-10 a.m.
Tuesday, Aug. 13	12-1 p.m.
Wednesday, Aug. 21	9-10 a.m.
Wednesday, Aug. 28	9-10 a.m.

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Date	Time
Wednesday, Sept. 4	12-1 p.m.
Wednesday, Sept. 11	9-10 a.m.
Tuesday, Sept. 17	12-1 p.m.
Thursday, Sept. 26	12-1 p.m.
Tuesday, Oct. 1	9-10 a.m.
Wednesday, Oct. 9	9-10 a.m.
Wednesday, Oct. 16	9-10 a.m.
Wednesday, Oct. 23	12-1 p.m.
Tuesday, Oct. 29	9-10 a.m.
Wednesday, Nov. 6	9-10 a.m.
Wednesday, Nov. 13	9-10 a.m.
Wednesday, Nov. 20	9-10 a.m.
Tuesday, Dec. 3	9-10 a.m.
Wednesday, Dec. 11	9-10 a.m.

To register, send an email to SEprofessionaleducationregistration@bcbsm.com and include the date and time of the class you wish to attend. You will receive a confirmation within 72 hours of registering.

It's important to register so that we can send you information about the webinar and the conference call-in number. This information may vary, depending on the session.

Here's how you can access the coding initiative computer-based training on web-DENIS:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- Under "What's New," check out the BCBSM coding initiative presentation.

The presentation is also available on the Blue Care Network Provider Publications and Resources site on the Learning Opportunities page.

Please contact your provider consultant with questions related-the webinars or computer-based training.

Accurate payments for dermatology services require correct coding

It's important to provide the correct codes and pertinent details for dermatology services. This will ensure you receive appropriate and timely payment.

We realize that it sometimes can be a challenge to select the correct codes and related modifiers. We've found that the most common billing errors occur with modifier 25 and 59.

Modifier 25 is used with an evaluation and management code when a significant, separately identifiable E&M service by the same physician on the same day of another procedure or service.

Modifier 59 is used with a procedure code for a distinct service performed independently from other non-evaluation and management procedures on the same day. Documentation must support a different or separate session, procedure, surgery, site or organ system, incision, excision or lesion performed on the same day by the same physician.

Here are examples of how to apply these key modifiers to patient situations:

- During a yearly physical exam, the doctor discovers the patient has developed actinic keratosis. When documentation supports a separate and distinct evaluation — assessment and treatment of actinic keratosis — the evaluation and management service is separately payable. Modifier 25 should be applied to the appropriate evaluation and management code.
- A doctor examines a patient for a lesion and finds another distinct lesion present. The doctor treats both lesions. Modifier 59 may be applied to the code reporting treatment of the second lesion because it is considered a separate and distinct procedure.

If you have questions about coding for dermatology services, consult your provider manual on web-DENIS for documentation guidelines or contact your provider consultant.

Reminder: Follow documentation guidelines for physician office infusion therapy

To avoid potential recoveries, please be sure patient medical records correctly document physician office infusion therapy visits.

Blue Cross Blue Shield of Michigan requires you to follow its *Documentation Guidelines for Physicians and Other Professional Providers.* Our auditors use these guidelines to ensure the services, treatments, procedures and devices billed to us were provided in accordance with the provisions of your participation agreement. This means they were medically necessary, ordered by the physician, provided to the patient and documented in the medical record.

Electronic documentation and electronic signatures are accepted; however, it's important medical records accurately describe the services performed.

Please remember the following:

- Handwritten changes applied to printed electronic medical records, such as writing over or crossing out without initialing, or any changes that make the documentation difficult to interpret will be considered illegible.
- All printed EMRs must be complete and properly identify the patient. The services provided during the visit must be described in the record and meet *Current Procedural Terminology* coding guidelines and BCBSM documentation guidelines.
- All staff involved with the patient prior to, during or after the encounter is responsible for documenting the services provided. The records must be dated and signed or initialed with the credentials of the person who performed the service.
- Verbal orders obtained by the office staff must be written, dated and signed or initialed by the staff member with his or her credentials, as well as dated and signed or initialed by the ordering physician.
- When administering an infusion, you must record the start and end time of the infusion as specified in the CPT manual. Only stating the total time of the administration is not permitted — for example, "20 minutes" is not sufficient.
- Any changes made to the printed EMR must be updated in the actual electronic record.

By providing this vital information, you can avoid potential audit recoveries by BCBSM.

BCBSM home infusion therapy benefits for Medicare patients clarified

In response to providers' inquiries, we're clarifying our home infusion therapy policy for patients who have the BCBSM commercial HIT benefit, with Medicare as their primary payer.

Determining which payer should be billed for home infusion therapy nursing services depends on who pays for the drug. Just because a patient is homebound, it doesn't mean Medicare is responsible for the nursing services associated with home infusion therapies.

For patients with the BCBSM HIT benefit who are receiving home infusion, the benefits include the cost of the following:

- Drugs
- Supplies used to administer drugs
- Administrative services
- Care coordination
- Diluents and solutions
- Flushes
- Nursing services
- Professional pharmacy services

For homebound patients who have Medicare and the BCBSM HIT benefit, keep the following in mind:

- Medicare is primary only if it is paying for the patient's home infusion therapy. This is extremely limited and must be approved by Medicare.
- BCBSM becomes primary when the home infusion therapy ordered is not covered by Medicare.

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- When BCBSM pays for the home infusion therapy, all of the BCBSM HIT benefit requirements need to be met by the infusion provider.
- The HIT benefits include required nursing services. This is covered in the BCBSM HIT manual and contract.

BCBSM pays for home infusion therapy when:

- The home care agency can bill Medicare for nursing visits unrelated to home infusion therapy.
- The infusion provider cannot bill Medicare for nursing services. The infusion provider can bill BCBSM for home infusion therapy and the related nursing services, as stated in the BCBSM home infusion therapy benefit requirements.
- If the infusion provider subcontracts with the infusion nurse from the home care agency that is providing the Medicare skilled nursing services, the following applies:
  - The home care agency is a subcontractor and considered an employee of the HIT provider.
  - During infusion nursing visits, the nurse is considered an employee of the infusion provider.
  - The home care nursing agency may not bill BCBSM or Medicare for an infusion-related nursing visit.
  - The HIT provider bills all infusion-related nursing visits to BCBSM.
  - The infusion nursing visit is considered a separate visit and requires a separate nursing note with the focus on the infusion-related care.
  - The nursing note must reflect the BCBSM Home Infusion Therapy Provider manual description of nursing visits. For more information, see the "Conditions and Limitations, Nursing Visits" section of the manual.

Home infusion therapy nursing guidelines clarified

This brief overview should help clarify our guidelines and exceptions for home infusion therapy providers' nursing services.

The HIT benefit requires that:

- Nursing should be provided to all members who are HIT patients receiving home infusion therapy.
- BCBSM home infusion therapy nursing visits may only be provided by a registered nurse who has specialized education or training in home infusion therapy services.
- Licensed practical nurses are not eligible to provide home infusion therapy nursing.
- This requirement also applies when the nursing is subcontracted.
- RN availability also applies to patients who travel outside the home infusion or nursing agency service area.
- Nursing orders require a physician signature.

When reporting HIT visits:

- The HIT provider should use procedure code *99601 for the first two hours of each visit. Additional hours that same day can be reported under code *99602. However, this code can only be used if an RN stays longer than the initial two hours or if a separate nursing visit was conducted later the same day.
- BCBSM home infusion therapy allows payment for code *99602 only when the RN documents the visit start and stop time. In order to use this code, the additional time must be a minimum of 31 minutes and up to one hour beyond the initial two hours.
- HIT providers should not report more than four hours of nursing services per day and no more than 12 hours per week. Code *99602 can only be used in conjunction with code *99601.
- In addition, the benefits state that daily therapies require a minimum of one nursing visit per week, with a maximum of three visits per seven days.

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BCBSM will consider paying for additional nursing visits if:

- There are catheter issues, including patency restoring, catheter repair, PICC and midline insertion, and peripheral restarts.
- The drug manufacturer recommends extended infusion time and continuous monitoring of the infusion by an RN.

The nursing documentation:

- Should include an evaluation of the patient's response to the therapy relating to his or her diagnosis
- The HIT manual states: "The purpose of a nursing visit is to provide venous access, catheter care, assessment of the patient's infusion technique and any education that is related to the infusion therapy during the nursing visit. Additionally, the nursing visits are to assess the patient's progress, response to and changes in treatment, as well as documentation of any therapy that the RN administered during the visit."
- The nursing assessment must have measureable outcomes

BCBSM may waive the nursing requirement if all the below apply:

- Patients consider themselves independent or no longer want or require nursing visits. But there must be documentation in the clinical record that the patient or caregiver is capable and willing to provide his or her own infusion-related care.
- The patient's physician provides an order stating he or she is in agreement.
- The signed physician's order contains a statement allowing an RN to visit the patient on an as-needed basis.
- Once an order is signed, it must be added to all future Certificates of Medical Necessity and will require renewal every 120 days.

For additional information about HIT nursing care, please read the HIT manual or participation agreement.

Capitated Lab Program group numbers updated

Blue Cross Blue Shield of Michigan has updated the Capitated Lab Program group numbers for 2013. Please be sure to review the chart at right and ensure the lab work for these Blues PPO members are referred to Quest Diagnostics.

Quest Diagnostics is the only independent clinical lab provider for the Capitated Lab Program.

Delphi	72100, 72200, 72137, 72240
Ford	87950, 87951
GM	83200
MPSERS	59000 (new MOS group number 00701384)
TRW	73193

Updated training schedule for 2013

We want to make sure you have the tools you need to do business with us, so we have scheduled the following professional training opportunities for 2013.

Classes that are italicized have been changed to offer in-person training on coding. Additional classes may be offered, and we'll publish that information in future issues of *The Record*.

- All South Lyon classes will be in the Midnight Training Room at the Lyon Meadows Conference Center, 53200 Grand River, New Hudson.
- All Lansing classes will be in the Lower Level Auditorium, 232 S. Capitol Ave., Lansing.
- Morning or full-day classes start at 9 a.m., with registration beginning at 8:30 a.m.

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- Afternoon classes start at 1 p.m., with registration beginning at 12:30 p.m.
- Please note that on some dates the class in the afternoon is different from the morning session.
- Classes might extend later or end earlier depending on participant questions and computer-based training offered.

You will have access to web-DENIS and Provider Secured Services during the sessions, so please bring your web-DENIS user ID and password. You will not need any additional reference materials or manuals.

To register send an email to SEprofessionaleducationregistration@bcbsm.com. Indicate the date and time of the class you wish to attend. You will receive a confirmation within 72 hours of registering. It's important to register so that we may contact you in the event that a class needs to be rescheduled or is cancelled due to low enrollment.

The Blues will provide continuing education credits through AAPC.

For more information, please contact your provider consultant.

Location	Class	Time	Date
South Lyon – Midnight Training Room	Mental Health, Licensed Master's Social Workers, Provider Enrollment and Data Management	9 a.m.	Tuesday, April 16, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer for LMSWs	1 p.m.	Tuesday, April 16, 2013
South Lyon – Midnight Training Room	Best Practices, Billing Basics, PEDM	9 a.m.	Thursday, May 2, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, May 2, 2013
South Lyon – Midnight Training Room	ICD-10	9 a.m.	Thursday, May 9, 2013
South Lyon – Midnight Training Room	BlueCard®, Coordination of Benefits, PEDM	1 p.m.	Thursday, May 9, 2013
South Lyon – Midnight Training Room	Medical and Dental, PEDM	9 a.m.	Thursday, May 16, 2013
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Thursday, May 16, 2013
Lansing – Lower Level Auditorium	Medicare Advantage PPO	9 a.m.	Thursday, May 23, 2013
South Lyon – Midnight Training Room	Informational Session	9 a.m.	Tuesday, June 4, 2013
South Lyon – Midnight Training Room	BlueCard, PEDM, COB	1 p.m.	Tuesday, June 4, 2013
South Lyon – Midnight Training Room	IOT, ISPT, PEDM	9 a.m.	Thursday, June 6, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, June 6, 2013
South Lyon – Midnight Training Room	Physician Group Incentive Program, Patient-Centered Medical Home, Organized Systems of Care, Provider-Delivered Care Management	9 a.m.	Tuesday, June 11, 2013
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Tuesday, June 11, 2013
South Lyon – Midnight Training Room	Mental Health, LMSW, PEDM	9 a.m.	Thursday, June 13, 2013

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Location	Class	Time	Date
South Lyon – Midnight Training Room	Home Infusion Therapy	9 a.m.	Tuesday, June 18, 2013
South Lyon – Midnight Training Room	Informational Session, Bluecard, COB	1 p.m.	Tuesday, June 18, 2013
South Lyon – Midnight Training Room	Medicare Advantage PPO	9 a.m.	Thursday, June 20, 2013
South Lyon – Midnight Training Room	*Focused Coding Session (Detailed information related to our expectations on coding for professional services)* *Questions will also be answered as they relate to the Performance Reward Program, Health e-Blue Tool and Coding Related to Risk Adjustment.*	1 p.m.	Thursday, June 20, 2013
South Lyon – Midnight Training Room	IPT, PEDM	9 a.m.	Thursday, June 27, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, June 27, 2013
South Lyon – Midnight Training Room	Mental Health, PEDM	9 a.m.	Thursday July 11, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, July 11, 2013
South Lyon – Midnight Training Room	ICD-10	9 a.m.	Tuesday, July 9, 2013
South Lyon – Midnight Training Room	Best Practices, Billing Basics, PEDM	9 a.m.	Tuesday, July 16, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Tuesday, July 16, 2013
South Lyon – Midnight Training Room	Medicare Advantage PPO	9 a.m.	Thursday, July 18, 2013
South Lyon – Midnight Training Room	*Focused Coding Session (Detailed information related to our expectations on coding for professional services)* *Questions will also be answered as they relate to the Performance Reward Program, Health e-Blue Tool and Coding Related to Risk Adjustment.*	1 p.m.	Thursday, July 18, 2013
South Lyon – Midnight Training Room	Informational Session, PEDM	9 a.m.	Tuesday, July 23, 2013
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Tuesday, July 23, 2013
South Lyon – Midnight Training Room	Durable Medical Equipment, Medical Supplies	9 a.m.	Thursday, Aug. 1, 2013
South Lyon – Midnight Training Room	Prosthetics and Orthotics	1 p.m.	Thursday, Aug. 1, 2013
South Lyon – Midnight Training Room	Informational Session	9 a.m.	Tuesday, Aug. 6, 2013
South Lyon – Midnight Training Room	BlueCard, COB, PEDM	1 p.m.	Tuesday, Aug. 6, 2013
South Lyon – Midnight Training Room	Medical and Dental, PEDM	9 a.m.	Tuesday, Aug. 13, 2013

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Location	Class	Time	Date
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Tuesday, Aug. 13, 2013
Lansing – Lower Level Auditorium	Medicare Advantage PPO	9 a.m.	Thursday, Aug. 15, 2013
South Lyon – Midnight Training Room	Best Practices, Billing Basics, PEDM	9 a.m.	Thursday, Aug. 22, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, Aug. 22, 2013
South Lyon – Midnight Training Room	Mental Health, PEDM	9 a.m.	Thursday, Aug. 29, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, Aug. 29, 2013
South Lyon – Midnight Training Room	ICD-10	9 a.m.	Tuesday, Sept. 10,2012
South Lyon – Midnight Training Room	Medicare Advantage PPO	9 a.m.	Thursday, Sept. 12, 2013
South Lyon – Midnight Training Room	*Focused Coding Session (Detailed information related to our expectations on coding for professional services)* *Questions will also be answered as they relate to the Performance Reward Program, Health e-Blue Tool and Coding Related to Risk Adjustment.*	1 p.m.	Thursday, Sept. 12, 2013
South Lyon – Midnight Training Room	Mental Health, LMSW, PEDM	9 a.m.	Tuesday, Sept. 17, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer for LMSWs	1 p.m.	Tuesday, Sept. 17, 2013
South Lyon – Midnight Training Room	PGIP, PCMH, OSC, PDCM	9 a.m.	Thursday, Sept. 19, 2013
South Lyon – Midnight Training Room	Documentation Guidelines, BlueCard, COB	1 p.m.	Thursday, Sept. 19, 2013
South Lyon – Midnight Training Room	Best Practices, Billing Basics, PEDM	9 a.m.	Thursday, Sept. 26, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, Sept. 26, 2013
South Lyon – Midnight Training Room	IOT, ISPT, PEDM	9 a.m.	Thursday, Oct. 3, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, Oct. 3, 2013
South Lyon – Midnight Training Room	Informational Session	9 a.m.	Thursday, Oct. 10,2013
South Lyon – Midnight Training Room	BlueCard, COB, PEDM	1 p.m.	Thursday, Oct. 10,2013
South Lyon – Midnight Training Room	PGIP, PCMH, OSC, PDCM	9 a.m.	Tuesday, Oct. 15, 2013
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Tuesday, Oct. 15, 2013
South Lyon – Midnight Training Room	Mental Health, PEDM	9 a.m.	Tuesday, Oct. 22, 2013

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Location	Class	Time	Date
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Tuesday, Oct. 22, 2013
South Lyon – Midnight Training Room	Medical and Dental, PEDM	9 a.m.	Tuesday, Oct. 29, 2013
South Lyon – Midnight Training Room	BlueCard, COB, Documentation Guidelines	1 p.m.	Tuesday, Oct. 29, 2013
South Lyon – Midnight Training Room	ICD-10	9 a.m.	Tuesday, Nov. 5, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer	1 p.m.	Tuesday, Nov. 5, 2013
South Lyon – Midnight Training Room	Home Infusion Therapy	9 a.m.	Thursday, Nov. 7, 2013
South Lyon – Midnight Training Room	Informational Session, Bluecard, COB	1 p.m.	Thursday, Nov. 7, 2013
South Lyon – Midnight Training Room	Durable Medical Equipment, Medical Supplies	9 a.m.	Tuesday, Nov. 12, 2013
South Lyon – Midnight Training Room	Prosthetics and Orthotics	1 p.m.	Tuesday, Nov. 12, 2013
South Lyon – Midnight Training Room	IPT, PEDM	9 a.m.	Thursday, Nov. 14, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Thursday, Nov. 14, 2013
South Lyon – Midnight Training Room	Best Practices, Billing Basics, PEDM	9 a.m.	Tuesday, Nov. 19, 2013
South Lyon – Midnight Training Room	web-DENIS, Benefit Explainer, BlueCard	1 p.m.	Tuesday, Nov. 19, 2013

Keep Michigan kids lead-free

Lead testing is a benefit for children covered by the MIChild program.

MIChild preventive care services are covered at 100 percent when provided by a Blue Cross Blue Shield of Michigan PPO provider. To assist in determining if your patients need to be tested for lead, the Michigan Department of Community Health developed specific exposure questions to determine a child's risk:

- Does the child live in or often visit a house, daycare, preschool, home of a relative, etc., built before 1950?
- Does the child live in or often visit a house built before 1978 that has been remodeled within the last year?
- Does the child have a sibling or playmate with lead poisoning?
- Does the child live with an adult whose job or hobby involves lead?
- Does the child's family use any home remedies or cultural practices that may contain or use lead?
- Is the child included in a special population group, such as being a foreign adoptee, refugee, migrant, immigrant or foster care child?

If parents or guardians answer "yes" or "I don't know" to any of the above questions, then the patient may need to be tested. If you would like more information regarding the lead testing criteria developed by the Michigan Department of Community Health, please visit **michigan.gov/documents/ScreenPlan_11223_7.pdf**.*

*Blue Cross Blue Shield of Michigan does not control this website or endorse its general content.

Keep your MIChild patients healthy

Checkups and immunizations help keep your patients healthy by protecting children and reducing the spread of diseases. With MIChild, members can receive:

- Unlimited well-baby visits (for children under 24 months)
- Annual health checkups (for children 2-19 years old)
- Annual female exams and Pap smear screenings
- All recommended vaccines, including the seasonal flu and H1N1 vaccine

MIChild covers vaccines for patients up to 19 years old. Visit the American Academy of Pediatrics website at **www2.aap.org/immunization/IZSchedule.html*** to view the 2013 Immunization Schedule.

If your office does not provide immunizations, please refer Blue Cross Blue Shield of Michigan MIChild members to a health care provider within the PPO network to ensure preventive services are covered at 100 percent with no cost to members.

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MMBA annual billing expo set for May 15

The Michigan Medical Billers Association's Sixth Annual Billing Expo will be May 15, 2013, at the Holiday Inn Gateway Centre in Flint.

Blue Cross Blue Shield of Michigan representatives will be among the many speakers who are presenting at this daylong event, which runs from 7:30 a.m. to 4 p.m. Topics include health care reform, ICD-10, medical record audits, compliance and appeals, along with orthopedic and payer updates.

Registration is open to MMBA members and non-members alike. You can register online at **mmbaonline.org***.

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Ambulatory infusion centers can apply now to contract with the Blues

Applications for ambulatory infusion centers interested in contracting with Blue Cross Blue Shield of Michigan and Blue Care Network are now available online for an effective date of Aug. 1, 2013.

As we reported in the February *Record*, BCBSM and BCN decided to contract with qualified ambulatory infusion centers to provide members with additional safe, convenient, cost-effective locations to receive infusion therapy.

AICs must participate with BCBSM and BCN to receive reimbursement. Physicians should make sure they refer patients to in-network AICs or other health care providers that offer infusion therapy services. Participating AICs will be identified in the provider directory on **bcbsm.com** by Aug. 1, 2013.

AICs interested in applying should go to **bcbsm.com** and click on the *Providers* tab:

- Click on *Sign up today*.
- Click on *Provider Enrollment*.
- Select *Hospitals and Facilities*.
- Follow the prompts to access the application form for ambulatory infusion centers.

You'll complete the form online, print it and fax it according to the instructions on the form.

To ensure that your application is processed in time for the Aug. 1, 2013, effective date, please submit your enrollment form as soon as possible.

If you have any questions, contact your provider consultant.

Authorization is required for partial hospitalization for eating disorders

Effective June 1, 2013, partial hospitalization programs for eating disorders must be authorized through Magellan Behavioral of Michigan Inc.

This applies to members enrolled in the Traditional, PPO and Blue Choice PPO℠ programs whose mental health benefit is managed by Magellan on behalf of Blue Cross Blue Shield of Michigan. This does not apply to customer groups that have chosen a third party to administer their behavioral health benefits.

To obtain authorization, please call Magellan at 1-800-762-2382. For FEP and Blue Choice PPO members, call the toll-free number for behavioral health on the back of the member's ID card.

This authorization process applies to all designated and non-designated facilities for Blue Cross Blue Shield members.

You can find the clinical criteria for partial hospitalizations in the Magellan Behavioral Health Inc. *Medical Necessity Criteria Guidelines*. To access this information in web-DENIS:

- Log in to web-DENIS.
- In the left-hand navigation, click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters and Resources.*
- Click on *Clinical Criteria & Resources.*
- Scroll down to Resources and *2013 updated Magellan Behavioral Health Medical Necessity Criteria.*
- Click on *2013 Magellan Behavioral Health Medical Necessity Criteria.*

Enhancements to hospital prenotification system to be implemented in August 2013

In response to customer requests, Blue Cross Blue Shield of Michigan is enhancing its hospital prenotification system to capture data that will better support inpatient admissions. The changes will be implemented in August 2013.

They include the following:

- BCBSM will require all hospitals to reference InterQual® criteria for inpatient admissions and indicate which subset was referenced and met. If a doctor is overriding InterQual inpatient criteria, then the hospital must provide the doctor's name and phone number.
- Hospitals will be encouraged to enter symptoms exhibited at admittance and the necessary treatment.
- We will require hospitals to reference the Centers for Medicare & Medicaid Services inpatient surgical list for all Medicare Advantage PPO inpatient surgical procedures.
- If a physician is overriding the CMS inpatient surgical list, then the hospital must provide the physician's name and phone number.
- Hospitals will be required to provide an ICD-9-CM narrative for admissions. We ask that hospitals also enter the ICD-9-CM diagnosis code that corresponds with the narrative.

We'll provide additional details, including training opportunities, in a future issue of *The Record.*

2013 Michigan hospital networking sessions scheduled

Blue Cross Blue Shield of Michigan is hosting a series of networking sessions to provide hospitals with the information they need to do business with us.

The networking sessions will present information about hospital billing, medical policy, Medicare Advantage, BlueCard® and more. In addition to BCBSM, Blue Care Network and Medicaid information will also be presented at the sessions.

The sessions are from 9 a.m. to noon with registration beginning at 8:30 a.m. Coffee and continental breakfast will be served. Here are the scheduled dates for the sessions in 2013:

- Wednesday, June 26
- Wednesday, Sept. 25
- Friday, Dec. 6

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FACILITY

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The sessions will be in the auditorium at the Blue Care Network Commons building, 20500 Civic Center Dr., Southfield. There will be designated parking available.

To register for the sessions, send an email to sefacilityeducationregistration@bcbsm.com.

DME

Check monthly article for medical policy decisions

Are you missing critical and timely information affecting your business? The Blues urge you to read all sections of *The Record* for policy updates affecting durable medical equipment providers.

Medical and benefit policy changes may appear in the "DME" category or in the recurring article, "Blues highlight medical, benefit policy changes," found in the "All Providers" section. These changes may affect medical policy guidelines or medical necessity requirements for DME equipment, highlight a product type or refer to new documentation.

We published several DME-related articles in the past 12 months. Many of these appeared in the monthly article titled "Blues highlight medical, benefit policy changes." Please be sure to read that and other articles in the "All Providers" category each month.

MEDICARE ADVANTAGE

Reminder: Medicare Advantage Diagnosis Closure Incentive program replaces assessment form reimbursement

Blue Cross Blue Shield of Michigan and Blue Care Network have a new primary care physician Medicare Advantage Diagnosis Closure Incentive program for 2013. The new incentive applies to Blues Medicare Advantage patients, including those with BCN Advantage HMO-POS℠, BCN Advantage HMO℠, BCBSM Medicare Plus Blue PPO℠ and BCBSM Medicare Plus Blue Group PPO℠ coverage.

The new Diagnosis Closure Incentive program replaces reimbursement for completing the *Physician Assessment Form,* effective for dates of service Jan. 1, 2013, or later. The Diagnosis Evaluation reports are now available on Health e-Blue℠.

For more information about:	See the following document on Health e-Blue:
The Diagnosis Closure Incentive program	*2013 Diagnosis Closure Incentive Program* in the Resources section
The new Diagnosis Evaluation report on Health e-Blue	*Health e-Blue Phase 10.3 Enhancements March 2013* in the Resources section

See the January issue of *The Record* for details.

Health care providers may use the reports on Health e-Blue to document that diagnosis gaps have been closed. See below for instructions on how to apply for enrollment in Health e-Blue.

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Need 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:

- Click on *Provider Secured Services*.
- 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*.
- Complete all fields on both the Health e-Blue Application and the Use and Protection Agreement and return to the address on the form.

Please be sure to sign in to Health e-Blue at least every six months to maintain your access to the system.

Tips for signing up for Health e-Blue

- All applications need to be completed and signed by a primary care physician or PCP manager (Pages 5 and 6).
- The practice name has to match across the application.
- Provide state license number (can send additional pages if you are out of space).
- Include any previously created web-DENIS ID to help the Health e-Blue team provide faster service. (Web-DENIS IDs usually start with D or F.)
- Use your full legal name on the application.

If you have questions, call your BCBSM provider consultant or BCN provider representative.

New compliance language added to Medicare Advantage provider agreement

Please read the new compliance language in your *Medicare Advantage PPO Provider Agreement*. The language, required by the Centers for Medicare & Medicaid Services, takes effect July 1, 2013. BCBSM alerted you March 26 through web-DENIS about this change.

The new language in your agreement stems from a new Chapter 21 in the *Medicare Managed Care Manual* titled "Compliance Program Guidelines." Issued by CMS in 2012, it lists requirements for Medicare compliance. See **cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf***.

Blue Cross Blue Shield of Michigan must comply with the new guidelines. Your provider agreement requires you and your vendors to also comply with all CMS rules, regulations and guidelines. The new CMS guidelines aim to reduce Medicare fraud, waste and abuse through key compliance requirements.

Complying with the new guidelines also aligns you with future requirements of Section 6401 of the Patient Protection and Affordable Care Act. It requires Medicare, Medicaid and the Children's Health Insurance Program (MIChild in Michigan) to create compliance programs as a condition of enrollment.

Questions? Contact your provider consultant.

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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

Corporate Communications – MC 0245
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

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bcbsm.com

Visit our website at:
bcbsm.com

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