June 2013

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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 June issue on May 31.

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

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*.
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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 reject prescription drug claims when fraud, waste or abuse are indicated

Under a new Prescriber Prescription Block Policy, prescriptions written by a health care provider who prescribes drugs that are not medically necessary, may cause significant patient harm or are not appropriate for the documented medical condition will no longer be payable. This policy becomes effective Sept. 1, 2013.

In addition, if a provider is being investigated for fraud, waste or abuse — or has been sanctioned at the time the prescription is dispensed — the prescriptions he or she has written will no longer be payable. A sanctioned provider is one who has been sanctioned by the Office of the Inspector General, the Government Services Agency, the Centers for Medicare & Medicaid Services or state licensing boards.

BCBSM will notify sanctioned providers if they are subject to our Prescriber Prescription Block Program. BCBSM will also provide notice to affected members who have had a prescription written by the sanctioned provider within the past four months.

Following member and provider notification, BCBSM will implement claim processing changes to reject all prescription claims submitted to a pharmacy for prescriptions written or ordered by the provider. These claims will no longer be considered covered services for our members. The block will be effective for a period of five or more years.

If it is determined that the drugs are not medically necessary, may cause significant patient harm are not appropriate for the documented medical conditions, additional action may be taken, including:

- Case management
- Intervention by Pharmacy Services to institute quantity limits or other restrictions
- Preliminary investigation by BCBSM Corporate and Financial Investigations and possible requests to law enforcement for an independent investigation to determine whether there is fraud, waste or abuse (Prosecution of the prescriber or member will be pursued through law enforcement when appropriate.)

Prior to taking action under this new policy, BCBSM will:

- Conduct an investigation and prepare a detailed report of findings that includes a 60-day review of the prescriber's activity
- Obtain an opinion from a BCBSM medical consultant or contracted pain management consultant to confirm that the provider's prescribing patterns do not appear to be medically necessary
- Present findings and obtain approval for a BCBSM provider sanction from BCBSM executive leaders
- Present the findings and approvals to the Audit Investigative Committee to gain approval to place a provider on Provider Prescription Block (issue a BCBSM provider sanction)
    - The suspension of payments will be for a period of five years as approved by the Audit Investigative Committee.
    - The suspension will be effective 30 days after member notification.
    - Members will be afforded a 30-day notice that prescriptions written by the prescriber will no longer be honored and that they may seek medical care from other providers for prescriptions deemed medically necessary for their health conditions.
    - Notice will be sent to the provider.
    - The provider may appeal a suspension in writing to BCBSM within 30 days of receipt of the notice.
    - The written appeal will be reviewed by the vice president of Pharmacy Services, a BCBSM medical director and a BCBSM attorney.
    - A decision regarding the provider appeal would then be rendered within 30 days of receipt of the appeal. The decision of the review panel will be final.

Helping to protect patient and public safety

Blue Cross Blue Shield of Michigan takes the health and safety of its members seriously. That's why BCBSM investigates potential prescription fraud and abuse for its members through programs that continually review prescriptions submitted for payment.

Taking prompt action in situations where providers are prescribing a large number of controlled substances is necessary to help ensure patient and public safety. It also ensures that the group or member's benefits are being used in an appropriate manner, as outlined in a member's pharmacy certificate or plan description documents.

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  - The appeal panel has the right to extend the effective date of the block if additional information is required by the panel.
  - If a provider appeal is unsuccessful, the provider may apply for reinstatement following the term of the prescription block.
- BCBSM Pharmacy Services will administer the Prescriber Prescription Block process in conjunction with its pharmacy benefit manager.

Pharmacies will be notified via a fax-blast communication and will receive an electronic message indicating "Prescriber not covered" at the point-of-sale. The member may choose to pay for the prescription out-of-pocket, but the member will not be reimbursed by BCBSM.

Use appropriate modifier when billing high-risk and non-obstetric conditions for maternity patients

Our system is currently being updated to allow you to enter an evaluation and management procedure code with modifier 25 when billing for maternity patient visits for high-risk conditions or conditions unrelated to the pregnancy during the 270-day antepartum period.

The diagnosis code and documentation should support the patient's high-risk condition or other condition unrelated to the pregnancy for the purposes of post-audit review.

If you receive a claim rejection before our system update is complete, you may request reconsideration of services rendered by sending documentation to be reviewed through the appeals process.

For uncomplicated maternity cases, global maternity codes are used to indicate antepartum care, delivery and postpartum care. Generally, E&M codes are **not** used during the prenatal period, since global maternity codes include E&M components.

Be sure to use appropriate procedure codes, modifiers when reporting multiple births

When reporting multiple births, follow these guidelines:

1. Use the global maternity code (*59400, *59510, *59618 or *59610) for the specific method of delivery for the first delivery. Use this code only once.
2. Then use the delivery-only code (*59409, *59514, *59612 or *59620) for additional babies with modifier 59.

When only the delivery service is provided for multiple births, use the appropriate delivery code for subsequent births on separate lines with modifier 59.

Important note: Use the global maternity code only when services are provided by the same physician or physician group practice, and only if the member is eligible for coverage for the entire pre- and post natal period.

Documentation, coding resources available

Blue Cross Blue Shield of Michigan and Blue Care Network have created some resources to help you with documentation and coding.

- *Tips on Documentation and Coding for Professional Offices* is a series of reference cards.
- A proper coding and documentation webinar is also available.

Both are available at **bcbsm.com**. Here's how to find them:

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1. Log in to Provider Secured Services.
2. Click on *web-DENIS.*
3. Click on *BCBSM Provider Publications and Resources.*
4. Click on *Newsletters & Resources.*
5. Click on *Provider Training.*

Printed copies of the tip cards are available by contacting your BCBSM provider consultant. If you don't know who your provider consultant is, check out the "Blue Pages Directory" of your online provider manual. Or contact your regional provider relations manager as follows:

Region	Name	Phone
Mid-Michigan	Kate Simon	517-325-4590
Southeast Michigan	Laurie Latvis	313-225-7778
Upper Peninsula	Mike Fedrizzi	906-228-5457
West Michigan	Mike Pinder	616-389-2042

The webinar is also available directly (without accessing it through web-DENIS) at **brainshark.com/bcbsm/codinginitiative***.

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

New features added to Provider Enrollment and Change Self-Service

Many online Provider Enrollment and Change Self-Service Application users may have noticed that the application now offers new features. In March, it was enhanced so that users could add or modify information in the Practitioner Network Panel, including:

- Open practice status (accepting or not accepting new patients)
- Gender (of patients the practice is accepting)
- Age (of patients the practice is accepting)

If you have any questions about this enhancement or general questions about the Provider Enrollment and Change Self-Service Application, please call the Provider Enrollment Data Management department at 1-800-822-2761.

Summer training opportunities scheduled across state

We have scheduled professional training opportunities this summer at 15 locations around the state. The classes will cover important subject matter, including:

- Coding and documentation
- Risk adjustment
- Diagnostic evaluation incentive program
- Performance recognition program
- Health e-Blue℠
- Questions and answers

If additional classes are offered or the schedule changes, we'll publish that information in future issues of *The Record*.

- Full-day classes start at 9 a.m. and end at 4 p.m., with registration at 8:30 a.m.
- To accommodate driving time to the Upper Peninsula, classes there will begin one hour later than usual. Registration for Houghton, Marquette and Escanaba will be at 9:30 a.m., with class starting at 10.
- A lunch break will be provided between 12 and 1 p.m., with lunch served at all 15 locations.
- Classes might extend later or end earlier depending on participant questions.

To register, send an email to Jeff Holzhausen at jholzhausen@bcbsm.com. In the subject line, write "Professional" and the city where you wish to attend the class. Include the class date and the names and number of attendees expected from your facility.

You will receive a confirmation within 72 hours of registering. It's important that you register so we can have an accurate headcount for lunch.

The Blues will provide continuing education credits through AAPC.

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PROFESSIONAL

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For more information, please contact your provider consultant.

Class Location	Date
St. Joseph – Silver Beach Hotel, 100 Main St.	Tuesday, July 16, 2013
Kalamazoo – Radisson Kalamazoo, 100 West Michigan Ave.	Wednesday, July 17, 2013
Grand Rapids – Crowne Plaza Grand Rapids, 5700 28th St. S.E.	Thursday, July 18, 2013
Port Huron – McMorran Place, 701 McMorran Blvd.	Tuesday, July 23, 2013
Mt. Pleasant – Soaring Eagle Casino, 6800 Soaring Eagle Blvd.	Wednesday, July 24, 2013
Frankenmuth – Bavarian Inn Lodge, One Covered Bridge Lane	Thursday, July 25, 2013
Sterling Heights – Best Western Sterling Inn, 34911 Van Dyke Ave.	Tuesday, July 30, 2013
Ann Arbor – Weber's Inn, 3050 Jackson Road	Wednesday, July 31, 2013
Southgate – Holiday Inn Southgate – Banquet & Conference Center, 17201 Northline Road	Thursday, Aug. 1, 2013
Houghton – Magnuson Hotel Franklin Square Inn, 820 Shelden Ave.	Tuesday, Aug. 6, 2013
Marquette – Holiday Inn Marquette, 1951 U.S. 41 West	Wednesday, Aug. 7, 2013
Escanaba – Quality Inn & Suites, 2603 N. Lincoln Road	Thursday, Aug. 8, 2013
Alpena – Sanctuary Inn & Conference Center (formerly the Alpena Holiday Inn), 1000 U.S. 23 North	Tuesday Aug. 13, 2013
Gaylord – Treetops Resort, 3962 Wilkinson Road	Wednesday, Aug. 14, 2013
Traverse City – Holiday Inn West Bay, 615 East Front St.	Thursday, Aug. 15, 2013

ALL PROVIDERS

Follow these coding tips to improve medical record documentation for fractures, osteoporosis

Coding for fractures can be a challenge considering the different types of fractures and certain bone diseases that can impact a fracture. These conditions can vary from serious (requiring immediate treatment) to chronic conditions that may call for other treatment rather than just a cast or strapping procedure.

In this article, you'll find coding tips for traumatic and pathologic fractures (including aftercare for both) and osteoporosis, the most common bone disease.

Documentation and coding tips for traumatic fractures

Traumatic fractures are classified using ICD-9-CM categories 800 to 829. The three digits identify the bone involved, while a fourth digit indicates whether the fracture was open or closed and a fifth digit distinguishes the part of the bone affected. Review the information on coding fractures in the ICD-9-CM official guidelines in *Section 1.C.17.b.* A diagnosis is invalid if it has not been coded to the full number of digits required for that code.

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Common fracture terms

- Closed fracture: Commonly used terms may include simple, comminuted, depressed, elevated, fissured, greenstick, impacted, linear, slipped epiphysis or spiral.
- Open fracture: Terms may include compound, infected, puncture or "with foreign body."

To code multiple fractures, make sure the specific sites are coded individually and first list the most serious fracture, as determined by the attending physician. If the note is not clear, please don't assume and assign an incorrect code; ask the physician.

Pathologic fractures are assigned codes from ICD-9-CM 733.10-733.19. These codes are used for acute or a newly diagnosed pathologic fracture, and while the patient is receiving active treatment for it. Unlike fractures of normal bone, pathologic fractures occur during normal activity or from minor trauma due to weakening of the bone by disease, such as osteoporosis, neoplasms and osteomalacia.

Review the information on coding pathologic fractures in the ICD-9-CM Official Guidelines in Section 1.C.13.a. It's important to note that just because the patient has a bone weakening disease does not mean a fracture is pathologic. Only the physician can determine whether the fracture is traumatic or pathologic.

Terms synonymous with pathological fractures may include spontaneous fracture, non-traumatic compression, non-traumatic fracture or insufficiency fracture.

Coding for fracture aftercare
Aftercare codes for fractures are found in the supplementary classification V codes, located at the end of the tabular list.

- The range for traumatic fracture aftercare is V54.10-V54.19.
- The range for pathologic fracture aftercare is V54.20-V54.29.

The fourth digit distinguishes between traumatic and pathologic, and the fifth digit specifies the fracture site being treated. These codes are not assigned when treatment is directed at a current acute injury, but after active treatment of the fracture is completed and for routine care of the fracture during the recovery phase.

About ICD-9-CM

ICD-9-CM is the national coding language used to translate a patient's clinical condition into three- to five-digit codes. When reporting ICD-9-CM and current procedural terminology codes on claims, it's critical that they're supported by proper documentation in a patient's medical record. Accurate coding starts with correct documentation.

Examples of fracture aftercare include:

- Change or removal of cast
- Removal of external or internal fixation device
- Medication adjustment

Proper coding for osteoporosis
Osteoporosis is the most common bone disease. It's an abnormal loss of bone tissue that results in fragile or porous bones. It typically has no symptoms until a fracture occurs, usually in the wrist, hip or vertebra. The code selection for osteoporosis is 733.00-733.09. Review the ICD-9-CM manual for the appropriate code selection.

Coding tip when term 'rule out' used
A challenge in the outpatient setting occurs when the term "rule out" is used. For example, a patient presents with swelling and pain in the wrist and is sent to a radiologist to rule out a fracture. **It would be inappropriate to code a fracture until the condition is confirmed by the radiology report and the attending physician makes the determination**. The physician also can determine whether the fracture is traumatic or pathologic. Coding signs and symptoms is only acceptable when a definitive diagnosis has not been confirmed by the health care provider in the outpatient setting.

For more information, please contact your provider consultant.

Follow your filing limits; submit claims on time

We told you in the May 2013 issue of *The Record* that 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.

Follow these guidelines:

- 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.
- For secondary claims, status inquiries and adjustments, the deadline is within 24 months from the date of service.
- 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 a contract migrating to the Michigan Operating System are pay-subscriber claims. After migration to MOS, the provider is paid, and regular filing limits apply.

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.

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

Medicare Advantage claims must be filed within 1 year of service or discharge date

Please remember that health care providers must file all BCBSM Medicare Advantage claims, including revisions or adjustments, within one calendar year of the service or discharge date. Claims filed after one calendar year of the date of service or discharge will be the health care provider's liability, and providers may not balance bill the member.

We previously explained this requirement in a web-DENIS message posted Nov. 29, 2012. The information is also included in your *Medicare Advantage PPO Provider Agreement.*

You can access the *BCBSM Medicare Advantage PPO Provider Agreement* at **bcbsm.com/provider/ma**:

- Click on *Medicare Plus Blue PPO.*
- Click on *Provider Toolkit.*
- The *MA PPO Provider Agreement* is listed under "Plan Basics."

Please remember: Beginning with 2013 service dates, BCBSM transitioned all Medicare Advantage claims processing to a new claims vendor. We encourage providers to submit claims with 2012 service dates as soon as possible to avoid any processing delays.

HEDIS report shows progress for MIChild population

A recent Blue Cross Blue Shield of Michigan Healthcare Effectiveness Data and Information Set report highlighted progress in patient care.

Our 2012 HEDIS report on the MIChild population showed that:

- Seventy-six percent of the children received no antibiotic treatment for upper respiratory infections — a decrease of 1 percent from the prior year.
- Eighty-four percent of children received two or more A1c tests in 2011 — an increase of 17 percent from the previous year.

As you may know, the Centers for Disease Control and Prevention has been working to reduce the unnecessary use of antibiotics, which contribute to the growth of new drug-resistant germs and increases health risks for patients.

The CDC also has been working to stress the importance of ordering the A1c test for diabetic patients every three months if their test results are consistently below target and two times a year if results are within an acceptable range. The A1c test serves as a gauge to assess how well a patient's diabetes has been controlled over time.

We appreciate your continued efforts to provide the quality care that helps keep BCBSM members healthy.

9 new HCPCS codes added

The Centers for Medicare & Medicaid Services has added nine new HCPCS as part of its regular quarterly HCPCS updates.

The new codes are listed below.

Code*	Change	Coverage Comments	Effective Date
81504	Added	Not covered by BCBSM	July 1, 2013
9001F	Added	Not covered by BCBSM	Jan. 1, 2014
9002F	Added	Not covered by BCBSM	Jan. 1, 2014
9003F	Added	Not covered by BCBSM	Jan. 1, 2014
9004F	Added	Not covered by BCBSM	Jan. 1, 2014
9005F	Added	Not covered by BCBSM	Jan. 1, 2014
9006F	Added	Not covered by BCBSM	Jan. 1, 2014
9007F	Added	Not covered by BCBSM	Jan. 1, 2014
G0459	Added	Covered by BCBSM	Jan. 1, 2013

Blues highlight medical, benefit policy changes

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

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

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

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*.

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BENEFIT POLICY continued from Page 8

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
NEW PAYABLE PROCEDURES	
32701, 77520, 77522, 77523, 77525	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines for the Charged Particle (Proton or Helium) Radiation policy have been updated. This policy is effective July 1, 2013. **Inclusionary Guidelines** Charged particle irradiation with proton or helium ion beams is established for the following indications: • Primary therapy for melanoma of the uveal tract (iris, choroid or ciliary body), with no evidence of metastasis or extrascleral extension and with tumors up to 24 mm in largest diameter and 14 mm in height. • Postoperative therapy (with or without conventional high-energy X-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine. Patients eligible for this treatment have residual localized tumor without evidence of metastasis. • In the treatment of pediatric (through 21 years of age) central nervous system tumors. **Exclusionary Guidelines** • All other applications of charged particle irradiation, including localized prostate cancer and non-small-cell lung cancer at any stage or for recurrence are experimental. • Pediatric non-central nervous system tumors • Tumors of the head and neck (other than skull-based chordoma or chondrosarcoma).
75572-75574	**Basic Benefit and Medical Policy** Coronary computed tomography-angiography is an established procedure. It is a useful diagnostic procedure when indicated for patients meeting selection criteria. **Inclusionary Guidelines** **Update to guidelines** (effective July 1, 2013): Membership in the BCBSM Collaborative Quality Initiative for Emerging Non-Invasive Cardiovascular Imaging is **not** required when CCTA services are delivered for an approved indication (as stated in Inclusionary Guidelines section) in the **emergency department.** **Complete guidelines were published in the November 2012 *Record.***

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NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, S3833, S3834	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines for the Genetic Testing for Lynch Syndrome and Other Inherited Intestinal Polyposis Syndromes policy have been updated. This policy is effective July 1, 2013. **Inclusionary and Exclusionary Guidelines** These guidelines refer to the different types of genetic tests available for colorectal cancer. **A.** Genetic testing of the adenosis polyposis coli gene is established in the following: • Patients with greater than 20 colonic polyps • First-degree relatives (siblings, parents or offspring) of patients with FAP, AFAP or a known APC mutation. **B.** Genetic testing for MYH gene mutations is established in any of the following: • Individuals with personal history of adenomatous polyposis who have negative APC mutation testing and a negative family history for adenomatous polyposis • Individuals with personal history of adenomatous polyposis whose family history is consistent with recessive inheritance (family history is positive only for siblings) • Asymptomatic siblings of individuals with known MYH polyposis **C.** Genetic testing for MLH1 and MSH2 gene mutations to determine the carrier status of Lynch syndrome (HNPCC) is established in any of the following: • Patients with colorectal cancer to test for the diagnosis of Lynch syndrome • Patients with endometrial cancer and one first-degree relative diagnosed with a Lynch-associated cancer, for the diagnosis of Lynch syndrome • Patients without colorectal cancer, but who have a first- or second-degree relative with a known MMR mutation • At-risk relatives of patients with Lynch syndrome with a known MMR mutation • Patients without colorectal cancer but with a family history meeting the Amsterdam or Revised Bethesda criteria, when no affected family members have been tested for MMR mutations. **Continued on next page**

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NEW PAYABLE PROCEDURES

81201-81203, 81292-81301, 81317-81319, S3833, S3834 ***Continued***	• Amsterdam II Criteria: Must meet **all** of the following: – Three or more relatives with a histologically verified Lynch syndrome-associated cancer (colorectal cancer or cancer of the endometrium, small bowel, ureter or renal pelvis), one of whom is a first-degree relative of the other two – HNPCC-associated cancer involving at least two successive generations – Cancer in one or more affected relatives diagnosed before 50 years of age – Familial adenomatous polyposis excluded in any cases of colorectal cancer – Tumors should be verified by pathologic examination whenever possible • Revised Bethesda Guidelines: Patients must meet **any one** of the following: – Individuals diagnosed with colorectal cancer under the age of 50 – Individuals with Lynch syndrome-related cancer, including synchronous and metachronous colorectal cancers or associated extracolonic cancers** regardless of age – Individuals with colorectal cancer with the MSI-H histology diagnosed in a patient less than age 60 – Individuals with colorectal cancer and one or more first-degree relatives with colorectal cancer or Lynch syndrome-related extracolonic cancer**, if one of the cancers was diagnosed in a patient younger than 50 – Individuals with colorectal cancer and colorectal cancer diagnosed in two or more first- or second-degree relatives with Lynch syndrome-related tumors**, regardless of age **Extracolonic cancers include stomach, bladder, ureter and renal pelvis, biliary tract, brain (usually glioblastoma), pancreas, sebaceous gland adenomas, keratoacanthomas, carcinoma of the small bowel and endometrial or ovarian cancer. **Continued on next page**

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NEW PAYABLE PROCEDURES	
81201-81203, 81292-81301, 81317-81319, S3833, S3834 ***Continued***	**D.** MSH6 or PMS2 gene sequence analysis is established in patients meeting the Bethesda Criteria for genetic testing for Lynch syndrome: • Who do not have mutations in either the MLH1 or MSH2 genes • Who also meet the first Amsterdam II Criteria which describes the relatives • Single-site MSH6 or PMS2 testing is established for testing family members of persons with Lynch syndrome with an identified MSH6 or PMS2 gene mutation. **E.** Genetic testing for EPCAM mutations is established in any of the following: • Patients with colorectal cancer, for the diagnosis of Lynch syndrome when **all of the three** criteria are met: – Tumor tissue shows a high level of microsatellite instability – Tumor tissue shows lack of MSH2 expression by immunohistochemistry – Patient is negative for a germline mutation in MSH2, MLH1, PMS2 and MSH6 • At-risk relatives of patients with Lynch syndrome with a known EPCAM mutation • Patients without colorectal cancer but with a family history meeting the Amsterdam or Revised Bethesda Criteria, when no affected family members have been tested for MMR mutations and when sequencing for MMR mutations is negative Pre- and post-test genetic counseling should be provided as an adjunct to genetic testing.
NEW PAYABLE PROCEDURES	
90870	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines for the Electorconvulsive Therapy policy have been updated. This policy is effective July 1, 2013. Single electroconvulsive therapy is considered established. It may be considered a useful therapeutic option in specified situations. Multiple electroconvulsive therapy that is performed in one session is considered experimental. **Continued on next page**

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NEW PAYABLE PROCEDURES

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Continued

Inclusionary Guidelines
Single electroconvulsive therapy that is performed in one session when each of the following criteria are met:

1. The member has an index condition that is one of the following diagnoses:
   a. Bipolar Disorder
   b. Major Depressive Disorder
   c. Schizophrenia
   d. Schizoaffective Disorder
   e. Catatonia
   f. Neuroleptic Malignant Syndrome
2. The index condition is the primary cause of the member's symptomatology and functional impairment
3. The degree of symptomatology and functional impairment experienced by the member because of his or her index condition is characterized by at least one of the following:
   a. Is severe
   b. Is moderate and long standing (symptoms have been present for years)
   c. Is marked by catatonia
4. For schizophrenia and psychosis related to schizoaffective disorder, antipsychotic medications, unless otherwise contraindicated, are given concomitantly with ECT.
5. For schizophrenia and psychosis related to schizoaffective disorder, one of the following additional criteria is met:
   a. The member is experiencing an acute exacerbation of positive symptoms.
   b. The member is catatonic.
   c. The member is experiencing life-threatening inanition, stupor, suicidal risk or homicidal risk.
   d. At least two trials of maintenance antipsychotic medications, including clozapine, have failed to adequately treat the member's chronic positive symptoms.

      Note: Intolerance of a medication or dangerous side effects such as agranulocytosis associated with clozapine can result in "failure" despite adequate symptomatic improvement.

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NEW PAYABLE PROCEDURES

90870

Continued

6. For all conditions, at least one of the following additional criteria is met:
   a. Failure, at adequate dosages (as indicated by current literature) and duration of therapy, of at least two medications indicated for the treatment of the member's condition. "Failure" in this context means either:
      1. Lack of response: no response at maximum dosage after a period of time adequate for assessing initial response (for antidepressants, three weeks)
      2. Effect plateau: no continued improvement, at maximal dosage following a partial but inadequate initial response, over a period of time adequate for assessing whether a plateau has been reached (for antidepressants, two weeks)
      3. Intolerable or dangerous side effect regardless of clinical response
   b. A rapid response is required due to life-threatening inanition, stupor, suicidal risk or homicidal risk.
   c. Required medications cannot be safely taken by the member (for example, antipsychotics in the context of NMS)

7. The member has received a second opinion evaluation by a psychiatrist who regularly performs ECT or attends on patients receiving ECT and who is not involved in the direct care of the member. This opinion concurs with the plan for ECT.

8. An appropriate subspecialist has evaluated the patient and cleared him or her for ECT if the member is suffering from any of these relative contraindications for ECT:
   a. Recent myocardial infarction
   b. Cardiac arrhythmia
   c. Intracranial space-occupying lesion
   d. Severe pulmonary disease
   e. Severe osteoporosis
   f. Aneurism
   g. Arterio-venous malformation
   h. Severe hypertension
   i. Any other serious medical condition of concern to either the physician to be performing ECT or anesthesia

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NEW PAYABLE PROCEDURES	
90870 ***Continued***	**Exclusionary Guidelines** • Multiple electroconvulsive therapy that is performed in one session • Electroconvulsive therapy performed in the provider office setting
EXPERMENTAL PROCEDURES	
95199	**Basic Benefit and Medical Policy** Sublingual immunotherapy is considered experimental as a technique of allergy immunotherapy, as clinical efficacy has not been established. This policy is effective July 1, 2013.
L8699, L9900, V5267, V5298	**Basic Benefit and Medical Policy** Intraoral bone conduction hearing devices are not established for the treatment of hearing loss. While these devices may be safe, their effectiveness in this clinical indication has not been scientifically determined. Therefore, this service is experimental, effective July 1, 2013.
GROUP BENEFIT CHANGES	
County of Jackson (formerly known as Jackson County Road Commission)	Effective June 1, 2013, Medicare-eligible retirees of the County of Jackson will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO^{SM}, for their medical, surgical and prescription drug benefits. The group number is 60086 with suffixes 600 and 601. 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.** **Please note:** The Jackson County Road Commission has changed its legal name to County of Jackson. Its original effective date was April 1, 2013, but was changed to an effective date of June 1, 2013.
DFCU Financial	DFCU Financial will migrate from the Michigan Operating System to the NASCO platform, under new group number 71573, with the Blues on June 1, 2013. The group will offer one PPO plan with medical-surgical coverage and one prescription drug plan. Member ID cards will show the following alpha prefixes: DOU – PPO coverage DOF – Medicare PPO
Michigan Education Special Service Association (MESSA)	Effective July 1, 2013, Magellan Behavioral of Michigan will begin to perform inpatient mental health preauthorization for Michigan Education Special Service Association members. MESSA members can be identified by group numbers 71452-71455. Please continue to call the phone number on the back of the member's BCBSM ID card at 1-800-336-0022 for these requests.

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ALL PROVIDERS

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GROUP BENEFIT CHANGES	
National Employee Health Plan	Effective June 1, 2013, Medicare-eligible retirees of the National Employee Health Plan 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 60220 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.**

FACILITY

New documents, instructions, fax number available for nonhospital facility form submissions

In April, a new, easier-to-use nonhospital facility record update form and network agreement and signature documents were made available on the upgraded Facility Provider Enrollment website.

These nonhospital facilities forms include:

- *BCBSM/BCN New Facility Enrollment Form*
- *BCBSM/BCN Facility Change Form*
- Network agreement and signature documents — required for facilities wishing to participate in additional networks or for new facilities doing business with BCBSM and BCN (Network approvals are made after credentialing is completed.)

To download these forms, go to **bcbsm.com/providers**.

- Under *Join the Blues Network*, click on *Enrollment*.
- Click on *Provider Enrollment*.
- Click on *Hospitals and Facilities*.
- Select the type of facility.

Starting July 1, please follow these new instructions to submit enrollment forms:

- The fax cover sheet must be the first page of your submission.
- Fax the enrollment form and attachments (for example, contract signature documents) to 1-866-900-0250. Be sure to fax the registration information separately for each facility. (For example, if you register two or more facilities, you must complete and send a separate form and fax for each facility. They cannot be bundled into one fax transmission.)
- You can also mail the completed forms and documentation to:

  Provider Enrollment and Data Management
  Blue Cross Blue Shield of Michigan
  Mail Code C-334
  P.O. Box 217, Southfield, MI 48034

If you have any questions about nonhospital facility enrollment, call Provider Enrollment and Data Management at 1-800-822-2761.

If you have any questions about hospital enrollment, call BCBSM Hospital Contracting at 313-448-7892

Upper Peninsula facility training scheduled for August

We have scheduled facility training opportunities this August at three locations in the Upper Peninsula. The classes will include BCBSM billing and policy changes in the morning and web-DENIS and Medicare Advantage information in the afternoon.

To accommodate driving schedules to the Upper Peninsula, please note that classes will begin one hour later than usual.

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- Full-day classes start at 10 a.m. and end at 4 p.m., with registration at 9:30 a.m.
- A lunch break will be provided between 12 and 1 p.m., with lunch served at all three locations.
- Classes might extend later or end earlier depending on participant questions.

To register, send an email to Jeff Holzhausen at jholzhausen@bcbsm.com. In the subject line, write "Facility" and the city where you wish to attend the class. Include the class date and the number and names of attendees expected from your facility. You will receive a confirmation within 72 hours of registering. It's important that you register so we can have an accurate headcount for lunch.

For more information, please contact your provider consultant.

Class Location	Date
Houghton – Magnuson Hotel Franklin Square Inn, 820 Shelden Ave.	Tuesday, Aug. 6, 2013
Marquette – Holiday Inn Marquette, 1951 U.S. 41 West	Wednesday, Aug. 7, 2013
Escanaba – Quality Inn & Suites, 2603 N. Lincoln Road	Thursday, Aug. 8, 2013

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

BCBSM is launching an initiative to process professional medical drug claims at the national drug code level with the specific quantity that correlates to the NDC. We'll ask pharmacy and DME providers to submit NDC codes on claims for these drugs, starting July 1. This includes providers enrolled in the BCBSM Commercial (non-Medicare) Vaccine Program.

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

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

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

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

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

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

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

- The NDC must be submitted along with the applicable Healthcare Common Procedure Coding System or Current Procedural Terminology® code.

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SPECIALTY DRUGS continued from Page 17

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

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

- To submit paper claims, enter the NDC information in field 24 of the CMS-1500 claim. In the **shaded portion** of field 24A-24G, enter the qualifier "N4" left-justified), immediately followed by the national drug code. Next, enter the appropriate qualifier for the correct dispensing unit (GR, UN, ML or ME), followed by the quantity and the price per unit, as indicated in the example below.
- The format for billing should be:

  N4 + NDC code + 3 spaces + unit of measure + quantity

  Example: N4555103026710 ML5.5

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

- Reimbursement for discarded drugs applies only to single use vials. Discarded amounts of drugs in multi-use vials are not eligible for payment.
- For home infusion therapy and specialty drugs, health care providers must continue to submit claims with national drug code and National Council for Prescription Drug Programs quantities electronically.

Blues give instructions for Medicare Part D coverage determination process

For our Medicare Advantage health care providers, we've created an instruction guide for the Blue Cross coverage determination process for Medicare Part D. The *Blue Cross Blue Shield of Michigan Medicare Advantage Part D drug coverage guidelines* is available in Provider Secured Services on **bcbsm.com** and includes the following resources:

- An explanation of when and how to request a coverage determination
- The timeline for receiving a decision
- Links to our formularies

Our Part D formularies and drug-use guidelines encourage you to choose options that are low-cost as well as safe and effective.

In some cases, you may need to use a nonformulary drug or have the restrictions to the drug removed (e.g., quantity limit, prior authorization or step therapy requirements). In those situations, the Centers for Medicare & Medicaid Services requires that Medicare Part D plans provide patients and prescribers with a process to bypass these restrictions when medically necessary.

That process is also included in the instruction guide. It's located in Provider Secured Services:

- Go to **bcbsm.com**.
- Log in to Provider Secured Services.
- In the left-hand navigation, click on *BCBSM Publications and Resources.*
- Click on *Medicare Advantage Resources.*
- Under *What's New,* click on *Medicare Advantage provider coverage determination job aid*.

If you have any questions about coverage determination, please call our Clinical Pharmacy Help Desk at 1-800-437-3803 or your provider consultant.

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.

Once you log in, you can:

- View patient eligibility and benefits
- Subscribe to online newsletters
- Receive online payments and electronic vouchers
- Access newsletters, fee schedules and other resources
- And much more

Start using Provider Secured Services today. Go to **bcbsm.com/provider** to learn more.

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