July 2013

Articles in this issue…

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

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

When you subscribe, you'll receive the newsletter as an automatic email each month earlier than your printed edition reaches you. Blue Cross Blue Shield of Michigan typically sends the electronic *Record* on the last business day of the month. That means current subscribers should have received this July issue on June 28.

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

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

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

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

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

2013 InterQual® criteria implemented July 1

Blue Cross Blue Shield of Michigan will implement InterQual acute care, rehabilitation, skilled nursing, long-term acute care and home health criteria July 1, 2013. The criteria format for rehabilitation, skilled nursing, long term acute care and home care criteria have not changed.

In 2013, InterQual increased its condition-specific subsets to 29 adult and 22 pediatric acute care criteria. General medical and surgical subsets remain as in previous years for those patients who are not in the condition-specific subsets.

The Transition Plan section of the acute care criteria lists conditions associated with high risk of readmissions and an opportunity to refer your patients to our case management department. **For MESSA members, providers should contact MESSA at 1-800-441-4626.**

The acute care Quality Indicators section lists the quality indicators for improving the quality of hospital care. These indicators are the national standard sets developed by the National Quality Forum.

InterQual criteria should be applied to all elective or emergency hospital admissions.

The BCBSM modifications, or local rules, of the InterQual criteria were published on web-DENIS in late May. To access them:

1. Log in to web-DENIS.
2. Click on *BCBSM Provider Publications and Resources* in the left column.
3. Click on *Newsletters and Resources* in the left column or at the top of the page.
4. Click on *Clinical Criteria and Other Resources*.

BCBSM will offer comprehensive InterQual training statewide in the third quarter of 2013. Full day classes that focus on acute care in the morning and post-acute care in the afternoon are planned for Grand Rapids, Livonia, Traverse City and Marquette. Beginning in September, we will host webinars on the five criteria sets: acute, SNF, rehab, LTAC and HC.

Schedules for the classes and webinars will be in *The Record* and posted to web-DENIS.

InterQual® Criteria Helpline reminder

If you have questions, concerns or comments about InterQual® Criteria, you may email Blue Cross Blue Shield of Michigan at InterQualCriteria@bcbsm.com. We will respond via email.

The telephone InterQual Criteria Helpline transitioned to this email format several years ago.

Question format
In order for us respond to you accurately and quickly, provide the following information when emailing your questions:

- Indicate which criteria book you are using.
- Indicate the page number from that book.
- Reference which criterion or criteria you have a question about.
- Write your actual question, comment or concern.

For example:

Under “Acute Criteria, Adult” on Page ADLT-12 Acute Coronary Syndrome, INTERMEDIATE, Treatment:

Question: Do the newer oral anticoagulants alone meet this criterion?

Please remember to include your name and organization’s name.

New InterQual® criteria training classes offered this summer

Please join us for a free, in-person training session regarding the use of the new InterQual criteria, which are effective July 1, 2013, for Blue Cross Blue Shield of Michigan.

We will provide training and answer questions for all five InterQual criteria sets — acute care, rehabilitation, skilled nursing, long-term acute care and home health care.

BCBSM-specific modifications to the criteria are now posted to web-DENIS.

Registration begins at 8:30 a.m. Classes start at 9 a.m. and end at 4 p.m. Lunch is provided. The morning portion of the class will focus on acute care, while the afternoon will focus on post-acute sets.

INTERQUAL TRAINING continued on Page 3

INTERQUAL TRAINING continued from Page 2

Please note: To accommodate travel schedules in the Upper Peninsula, registration for the Marquette class begins at 9:30 a.m., with the class beginning at 10 a.m. All other locations have an 8:30 a.m. registration time.

Please be sure to sign up in advance for these classes.

Dates and locations
July 30, 2013
Crowne Plaza Hotel-Airport
5700 East 28th St., S.E.
Grand Rapids

Aug. 2, 2013
Sheraton Novi/Detroit
21111 Haggerty Road
Livonia

Aug. 7, 2013
Holiday Inn West Bay
615 East Front St.
Traverse City

Aug. 9, 2013
Holiday Inn
1951 U.S. 41 West
Marquette

To sign-up
Email Jeff Holzhausen at jholzhausen@bcbsm.com. Please write "InterQual training" in the subject line and include your name, title, organization and desired class date and location. We'll send you an email confirming your registration.

Questions? Call Jeff Holzhausen at 313-983-2106.

There's still time to sign up for summer training classes

If summer is here, can professional and facility training opportunities be far behind?

In the June *Record*, we ran two articles with complete details on classes scheduled for July and August. If you missed them, please refer to the following two articles in last month's issue:

- "Summer training scheduled around the state" (professional training), Page 4
- "Upper Peninsula facility training scheduled for August" (facility training), Page 16

To access our *Record* archives, follow these steps:

- Go to **bcbsm.com/providers**.
- Click on the *Newsletters* tab.
- Click on *The Record Archive*.
- Select the June 2013 issue.

If you have any questions, contact your provider consultant or send an email to Jeff Holzhausen at jholzhausen@bcbsm.com.

Blues' health care reform information designed with you in mind

Health care is changing quickly and everyone is feeling the effects. Whether you are a health care provider, a payer, an employer or a patient, it's hard to keep up with all the new information that seems to be available every day. The biggest changes in the next few years for all of us are related to health care reform.

In the upcoming months, we'll publish many articles about health care reform in our newsletters. Some of the topics that we'll cover will be:

- Mandates that are part of the Patient Protection and Affordable Care Act
- Information about the new plans in Health Insurance Marketplace
- Notification of upcoming informational sessions related to reform
- How and where to get the most up-to-date information

In addition to articles, we'll also update information about health care reform on our website, in your online manuals and on web-DENIS.

We understand that these changes will impact your practices and facilities, and we're working to get you the information you need to do business with us.

We'll introduce new informational edits for electronic claims in August

In an ongoing effort to improve the quality and security of our electronic connections, Blue Cross Blue Shield of Michigan is modifying the controls used in the electronic data interchange enrollment process.

On Aug. 19, 2013, we'll introduce new informational edits to ensure that a billing provider's national provider identifier is associated with the submitter code on file for electronic 837 claim transactions. Initially, the new edits will be informational to alert trading partners of a mismatch when the NPI and submitter code combination used on the claim does not match the combination the provider used to enroll with the EDI clearinghouse.

The following informational edits will **not** cause a claim's rejection, but they **do** require submitters to take action:

Professional – Returned on a 277CAX informational report

- A2 24 85 P001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR BCBSM/BCN
- A2 24 85 P002i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR MEDB/MED ADV
- A2 24 85 P003i BILLING NPI/SUB ID COMBO NOT AUTHORIZED FOR COMMERCIAL

Institutional – Returned on a 277CAZ informational report

- A2 24 85 F001i BILLING NPI/SUB ID COMBO NOT AUTHORIZED

Note: These informational edits will only be returned on 277CAX and 277CAZ reports, not in 277CAP transactions.

If you receive any of these edits, we recommend you first double-check your claims to ensure you reported the correct billing provider NPI. If correct, you will need to update your *Provider Authorization Form* with the appropriate billing NPI and submitter code combination. Instructions on how to update the *Provider Authorization Form* are available at **editest.bcbsm.com/tpalogon.html**.

It's critical that trading partners correct these inconsistencies by the end of 2013. In early 2014, the informational edits will convert to "hard edits" of P001, P002, P003 and F001 and claims will be rejected.

If you have questions about the new edits or the *Provider Authorization Form* process, call the EDI Helpdesk at 1-800-542-0945 or send an email to EDISupport@bcbsm.com and include "Trading Partner Agreement" or "TPA" in the subject line.

Keep these coding tips in mind to improve medical record documentation

Over the past few months, we've shared coding tips for certain diseases in an effort to help you improve medical record documentation. Coding for musculoskeletal and connective tissues disease can be challenging — that's why we've included some tips below for the most common musculoskeletal and connective tissue diseases. Musculoskeletal and connective tissue diseases are classified in codes 710-739 in the ICD-9-CM manual.

Lupus erythematosus — This is an autoimmune and chronic inflammatory disease that can affect many parts of the body, including skin, joints, kidneys, heart and lungs. The ICD-9-CM code for systemic lupus is 710.0. Watch for the message "use additional code," which instructs providers to use an additional code to identify any manifestation.

Rheumatoid arthritis — Considered a chronic condition, rheumatoid arthritis may be ascertained by reading a patient's past medical history or by checking a problem list. Remember that joint pain or a diagnosis of arthritis is **not** considered RA. According to the current *American College of Rheumatology* guidelines and clinical practice standards, patients with this condition require the initiation of disease-modifying anti-rheumatic drug therapy within three months of diagnosis.

Accurate management and documentation are also important for HEDIS performance measurement purposes. Chronic diseases, such as RA, which are treated on an ongoing basis, may be coded and reported as many times as the patient is receiving treatment and care for the condition. The ICD-9-CM code for rheumatoid arthritis is 714.0. Watch for the message "use additional code," which instructs providers to use an additional code to identify any manifestation.

Osteoarthritis — The most common type of arthritis, osteoarthritis is a chronic joint disorder characterized by degeneration of joint cartilage and the adjacent bone. It usually occurs in the hands, knees, hip and spine.

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OA is also referred to as degenerative joint disease, hypertrophic arthritis and degenerative arthritis. OA for most sites, excluding the spine, is assigned codes from category 715. Osteoarthritis of the spine is assigned to category 721. For category 715, the fourth digit identifies whether the OA is generalized or localized, and the fifth digit identifies the specific site involved.

- **Generalized osteoarthritis** affects many joints and is assigned ICD-9-CM code 715.0X. If it involves more than one site, but it's not specified as generalized, use code 715.8X.
- **Localized osteoarthritis** affects the joints of one site and is further identified as either primary or secondary.
  - **Primary —** Generally occurs in individuals 55 or older and is associated with aging, affecting joints of one site with no known cause (idiopathic). In this instance, use code 715.1X.
  - **Secondary –** Affects a joint of one site and has a specific cause, such as an injury, another disease process, inactivity or genetics. In this instance, use code 715.2X.

Note: If the localized osteoarthritis isn't specified as primary or secondary, use code 715.3X. If the osteoarthritis isn't specified as generalized or localized, the appropriate code is 715.9X.

Sacroiliitis — This condition occurs when pain is caused by inflammation of the sacroiliac joint that attaches the sacrum to the pelvis. Sacroiliitis is often missed or inappropriately treated.

Sacroiliitis can occur as a complication of infections in the heart, skin, joints or muscle. It also can follow a back injury. Many times, sacroiliac pain is mistaken for another cause of low back pain, such as a ruptured disk, collapsed vertebra, spinal stenosis or osteoarthritis of the joints in the spinal cord. Sacroiliitis may also be part of an inflammatory arthritic condition known as ankylosing spondylitis. For ankylosing spondylitis, the ICD-9-CM code is 720.0; for sacroiliitis, use the code 720.2.

Osteoporosis — The most common bone disease, osteoporosis falls into two categories, primary and secondary.

- There are three types of primary osteoporosis:
  - Postmenopausal **—** Caused by lack of estrogen; use code 733.01.
  - Senile **—** Results from an age-related calcium deficiency; use code 733.01.
  - Idiopathic **—** Typically occurs in young adults with no obvious reason for the weak bones; use code 733.02.
- Secondary osteoporosis is generally caused by certain medical conditions, hormonal disorders, disuse or is drug-induced. For disuse, the code is 733.03; for drug-induced, use code 733.09 and use an additional 'E' code to identify the drug. Refer to the *Official ICD-9-CM Guidelines* for coding and reporting.

For more information, please contact your provider consultant.

Remember these important BCBSM physical therapy updates, tips

As a physical therapist, it's important that you follow certain protocols. We've included some helpful reminders and updates for you to keep in mind.

Reconsideration of category assignment
Reconsideration of category assignment is a clinical oversight process to review factual or objective data that focuses on:

- Extreme, difficult or surgical cases
- Unique situations
- Additional episodes of care

You may request reconsideration:

- When your category assignment moves from category A or B, into category C
- By calling the Landmark Customer Service number at 1-877-531-9139
- Within 14 days of the Landmark categorization letter date stating the change

Reconsideration **will not** be an option if you have been placed in category C three or more consecutive times, as it gives no time to promote change. All information will be reviewed during the appeal process if requested.

The scope of the reconsideration is limited to **documenting additional episodes**. Additional episodes must fall within the same reporting period. Each reporting period contains 12 months of claims detail and is designated by the month and year in which the period ends. For example, the July 2012 reporting period includes claims from Aug. 1, 2011, to July 31, 2012.

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PHYSICAL THERAPY continued from Page 5

The episode may be:

- For a different body part
- Initiated following surgery
- Following a significant event, such as an auto accident

An episode of care is all physical therapy treatment provided to a member for a body part or related body part within a given 12-month period. Members who receive treatment for conditions for two distinct body parts within a reporting period **may** have two episodes.

Note: Waxing and waning of symptoms are not considered additional episodes.

Review of outlier cases
An outlier is a patient who requires higher intensity and duration of services. When working with an outlier patient, keep in mind:

- Documentation must demonstrate medical necessity for the services provided. You should review the clinical documentation before requesting the removal of a patient from the data to assure the patient and chart meet these criteria.
- Once information has been provided and reviewed, additional information will **not** be accepted.
- You must identify all outliers prior to starting the analysis.

Proper diagnosis for BCBSM claims
The primary diagnosis on the BCBSM claim is used to identify the body part being treated. The claims used for categorization include **only** the primary diagnosis and do not include any secondary diagnosis in relation to treatment. Please note:

- If treatment extends beyond the initial primary diagnosis or if additional treatment is equally primary, then you need to document the additional diagnoses at least once in the primary diagnosis field during the course of treatment.
- Due to the volume of reconsiderations, only the results will be shared. Final category affiliation decisions are subject to an appeal process.
- When you request a reconsideration, you must send data to Landmark and follow these requirements:
  - Once the reconsideration is requested, providers have 14 days to submit their information.
  - All information must be submitted at the same time.
  - All outliers must be identified at the time information is submitted.

BCBSM notification and recourse
Once you have been in category C for three consecutive categorization periods, you will receive notification from Blue Cross Blue Shield of Michigan. The purpose of this notification is to alert the provider to comply with network standards to avoid a disaffiliation notification.

A **disaffiliation notification** is a network termination notification that will be sent to all providers in category C for four consecutive categorization periods. At this time a provider may request a first level appeal through BCBSM if he or she doesn't agree with the notification, or the provider can voluntarily withdraw from the network.

Appeal process
If you don't agree with the disaffiliation notification, you can appeal it. You have two levels of appeals, they include:

- **First level appeal:** After the Blues review your first appeal, you'll be notified if it's pended, overturned or maintained and the appropriate steps you'll need to take.
- **Second level appeal:** This is your final opportunity to appeal your notification of disaffiliation. The Blues will determine if your second level appeal will be overturned or maintained.
- Instead of a second level appeal, you may voluntarily withdraw from the network.

If you're disaffiliated, you must follow these steps:

- You must notify your patients that you're no longer in the BCBSM PPO network.
- You may treat a BCBSM member; however the member's copay and deductible will be higher. You must clearly communicate this to the member.
- You must wait two years before you can reapply to the network, and you must meet the criteria to be accepted.

Billing reminders for credentialed physical therapists
Therapists who are credentialed as both outpatient physical therapists and independent physical therapists may not practice as an IPT out of their OPT facilities.

PHYSICAL THERAPY continued on Page 7

PHYSICAL THERAPY continued from Page 6

An IPT can work out of an OPT facility, but must bill under the facility and not on a professional claim. Once you're identified as a credentialed therapist, your provider representative will meet with you to discuss compliant billing practices.

For more information, call Deb Marvay at 313-448-8219, Blue Cross Blue Shield of Michigan, or call the Landmark Customer Service department at 1-877-531-9139.

Accommodating certain niche providers

A niche practice is where **a minimum** of 60 percent of patients require a higher intensity of care because they are post-surgical or have neurological impairments.

New Member Care Alert coming to web-DENIS eligibility screens

In an ongoing effort to provide you with resources to help you care for Blues patients, web-DENIS users will notice new Member Care Alert buttons on the web-DENIS eligibility screens in July.

The new alert buttons will be color-coded to help you identify patient needs quickly. Here are the three colors you may see and what they will mean:

MemberCareAlert **Red —** This member has an open diagnosis gap or treatment opportunity that requires action.

MemberCareAlert **Green —** This member has a pending or closed diagnosis gap or treatment opportunity. No action is required.

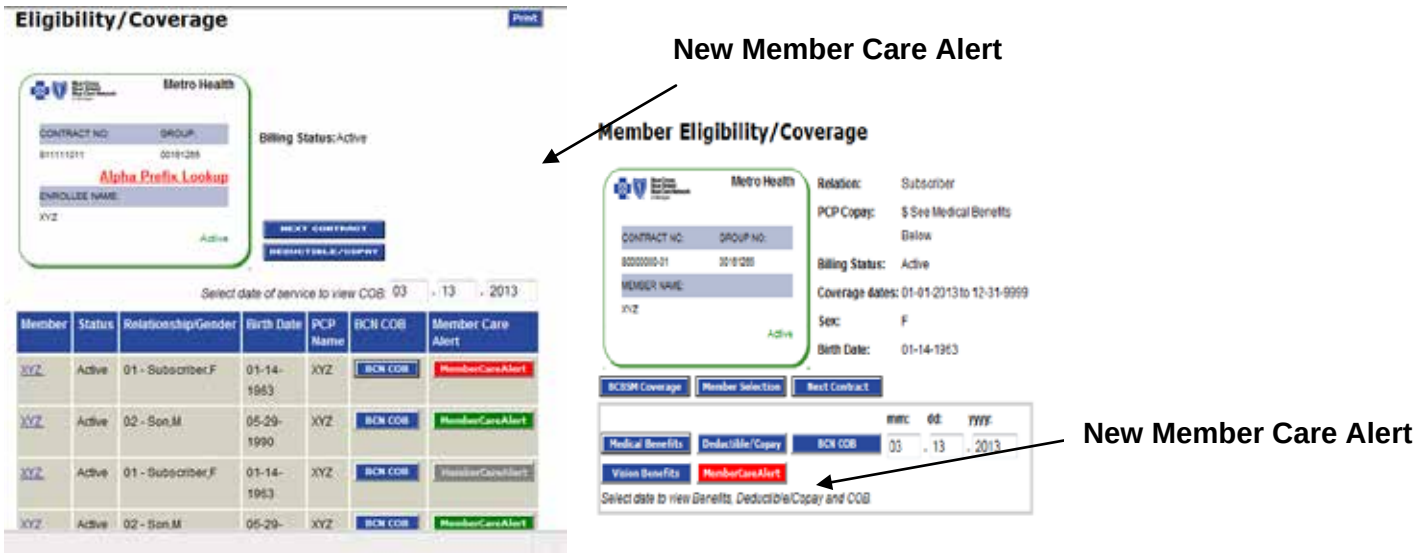
MemberCareAlert **Gray —** This member doesn't have a diagnosis gap or treatment opportunity at this time. No action is required.

A diagnosis gap is a suspected or historical condition that has not been documented and coded in the current calendar year or that has not been confirmed as not applicable to the member.

A treatment opportunity is a preventive service or treatment needed by the member, measured according to Healthcare Effectiveness Data and Information Set quality indicators.

The new Member Care Alert button will appear on the initial web-DENIS contract eligibility screen in a new column to the right.

The alerts will also appear on the individual member's eligibility screen.



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If you are a Blue Care Network primary care physician or a BCBSM Medicare Advantage PPO provider with access to Health e-Blue℠, clicking on one of these alert buttons will take you to Health e-Blue, where you may search for patient diagnosis gaps and treatment opportunities by clicking on the *Diagnosis Evaluation* panel or the *Treatment Opportunities* panel.

The new Member Care Alert button will appear for BCN commercial and Medicare Advantage patients and BCBSM Medicare Advantage patients covered under the following products: BCBSM Medicare Advantage PPO, BCNA, BCN commercial fully insured, BCN commercial self-funded, BCN65.

Over the coming months, watch for more enhancements to these screens that will bring even more functionality for efficiently closing diagnosis gaps and treatment opportunities.

If you are a primary care office and need access to Health e-Blue, register online today. Please contact your provider consultant if you need assistance.

HCPCS codes added

The Centers for Medicare & Medicaid Services has added 10 new HCPCS codes and one modifier as part of its regular quarterly HCPCS updates.

The new codes are listed below.

Code*	Change	Coverage Comments	Effective Date
C9131	Added	Not covered by BCBSM	July 1, 2013
C9736	Added	Not covered by BCBSM	July 1, 2013
G0460	Added	Not covered by BCBSM	July 1, 2013
K0008	Added	Requires manual review	July 1, 2013
K0013	Added	Requires manual review	July 1, 2013
K0900	Added	Requires manual review	July 1, 2013
Q0090	Added	Covered by BCBSM	July 1, 2013
Q2033	Added	Covered by groups with injection benefits	July 1, 2013
Q2050	Added	Covered by BCBSM	July 1, 2013
Q2051	Added	Covered by BCBSM	July 1, 2013
JE	Added	Informational only	July 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*.

Code*	**BCBSM Changes to:** **Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines**
NEW PAYABLE PROCEDURES	
E0675	**Basic Benefit and Medical Policy** The safety and effectiveness of outpatient limb pneumatic compression devices for venous thromboembolism prophylaxis have been established. They may be considered useful therapeutic options when clinical criteria are met, effective July 1, 2013. **Inclusionary Guidelines:** Outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis is indicated when one of the following criteria is met: · After major orthopedic surgery** in patients with a contraindication to pharmacological agents (i.e., at high-risk for bleeding) · After major non-orthopedic surgery in patients who are at moderate or high risk of venous thromboembolism with a contraindication to pharmacological agents (i.e., at high-risk for bleeding) · After major orthopedic or non-orthopedic surgery, as an adjunct to pharmacological therapy, in patients who are at **extremely high risk** for venous thromboembolism **Exclusionary Guidelines:** · Patients who are at low-risk of venous thromboembolism **Continued on next page**

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BENEFIT POLICY continued from Page 9

Code*	BCBSM Changes to: Basic Benefit and Medical Policy, Group Variations Payment Policy, Guidelines
NEW PAYABLE PROCEDURES	
E0675 ***Continued***	· Outpatient use of limb pneumatic compression devices for venous thromboembolism prophylaxis for periods longer than 30 days post-surgery **Major orthopedic surgery includes total hip arthroplasty, total knee arthroplasty, or hip fracture surgery. **Group Variations** · In addition to underwritten groups, the following groups are included: Delphi hourly and salaried · Chrysler nonbargaining unit CDHP/HSA (only group number 82100) · General Motors and UAW Retiree Medical Benefits Trust when BCBS has claim processing responsibility (POS 3 and others; except POS 4) · Federal Employee Program® The following groups are excluded from this policy: · Ford hourly and salaried · Chrysler bargaining unit and nonbargaining unit (except group number 82100) · GM and UAW Retiree Medical Benefits Trust when vendor (NNPN/HMENN) has claim processing responsibility (POS 4) · State of Michigan, MESSA and Michigan Public School Employee Retirement System
UPDATES TO PAYABLE PROCEDURES	
J9035	**Basic Benefit and Medical Policy** Avastin®, (bevacizumab) intravitreal injection is payable for intra-ocular diagnoses**.** Medical Affairs has approved the off-label use of Avastin (bevacizumab) for intra-ocular treatment of the following diagnoses:362.01, 362.02, 362.03, 362.05, 362.06, 362.07, 362.15, 362.16, 362.29, 362.30, 362.35, 362.36, 364.42, 362.52, 362.53, 365.63, 362.83, 362.84, 365.89 When using Avastin for the diagnoses listed above, report procedure code J9035.

BENEFIT POLICY continued on Page 11

BENEFIT POLICY continued from Page 10

POLICY CLARIFICATIONS	
30999, 82785, 86001, 86003, 86005, 86343, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95076, 95079, 95115, 95117, 95120, 95125, 95130-95134, 95144-95149, 95165, 95170, 95180, 95199	**Basic Benefit and Medical Policy** The exclusionary guidelines for the Allergy Testing and Immunotherapy policy has been updated. This policy is effective July 1, 2013. **Inclusionary Guidelines** **Allergy testing:** · Certain bronchial challenge tests · Direct skin test (percutaneous [scratch, prick or puncture] or intracutaneous [intradermal]) · Double blind food challenge test · Patch test (application test) · Photo patch test · Specific IgE in vitro tests (RAST, MAST, FAST, ELISA) · Total serum IgE concentration · Leukocyte histamine release test · Serial end point titration (SET or Rinkel method) when there is a high likelihood for a severe allergic reaction to specific agents such as antibiotics, nuts or other high-risk allergens **Immunotherapy treatments:** Appropriate in patients with demonstrated allergic hypersensitivity that cannot be managed by medications or avoidance. Note: Injections of airborne insect venom allergens should be prepared individually for each patient. **Exclusionary Guidelines** **Allergy testing that is not medically necessary:** · IgG (ELISA) Tests · Nasal challenge test · Passive transfer pr P-X (Prausnitz-Kustner) test · Provocative tests for food or food additive allergies · Rebuck skin window test **Allergy testing that is experimental:** · Conjunctival challenge test (ophthalmic mucous membrane test) · Direct nasal mucous membrane test · Cytotoxic food tests · Antigen leukocyte antibody test **(**ALCAT) · Mediator Release test **Continued on next page**

BENEFIT POLICY continued on Page 12

BENEFIT POLICY continued from Page 11

POLICY CLARIFICATIONS	
30999, 82785, 86001, 86003, 86005, 86343, 95004, 95017, 95018, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071, 95076, 95079, 95115, 95117, 95120, 95125, 95130-95134, 95144-95149, 95165, 95170, 95180, 95199 ***Continued***	**Immunotherapy treatments that are not medically necessary:** · Provocative and neutralization therapy for food allergies, using intradermal and subcutaneous routes · Rinkel, also known as serial dilution endpoint titration therapy, for ragweed pollen hay fever **Immunotherapy treatments that are experimental:** · Enzyme desensitivity therapy · Repository emulsion therapy · Urine auto injections (autogenous urine immunization) · Rhinophototherapy
76519, 92136	**Basic Benefit and Medical Policy** The CMS Physician Fee Schedule amount includes payment for the technical component (TC) for both eyes and one professional component (26) in the global service fee for procedure codes *92136 and *76519. These procedures should be reported on a single claim line without modifiers 50, RT or LT. If applicable, one additional line for the professional component (26) of the opposite eye may be reported.
97532	**Basic Benefit and Medical Policy** The safety and effectiveness of cognitive rehabilitation (as a distinct and definable component of the rehabilitation process) have been established. It may be considered a useful therapeutic option in the rehabilitation of patients meeting specific selection criteria. This policy is effective July 1, 2013. **Note: Please check individual contract, certificate and rider for specific coverage information.** **Inclusionary Guidelines** Cognitive rehabilitation is an established procedure when used an as adjunctive treatment of cognitive deficits (e.g., attention, language, memory, reasoning, executive functions, problem solving and visual processing) when all of the following criteria are met: · The cognitive deficits have been acquired as a result of neurologic impairment due to traumatic brain injury or stroke. · Services must be provided by a qualified licensed professional and must be prescribed by the attending physician as part of the written care plan. · There must be documentation of potential for improvements based on the patient's pre-injury function. **Continued on next page**

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BENEFIT POLICY continued from Page 12

POLICY CLARIFICATIONS	
97532 ***Continued***	· Patients must be able to actively participate in the program. The patient must have sufficient cognitive function to understand and participate in the program, as well as adequate language expression and comprehension (i.e., the patient should not have severe aphasia). · The member is expected to make significant cognitive improvement (e.g., member is not in a vegetative or custodial state). **Excluded diagnoses include, but are not limited to:** · Mental retardation · Cerebral palsy · Encephalopathy · S/P brain surgery · Dementia (e.g., from Alzheimer's disease, HIV-infection or Parkinson's disease) · Cognitive decline in multiple sclerosis and chronic obstructive pulmonary disease · Behavioral or psychiatric disorders such as attention-deficit hyperactivity disorder and schizophrenia · Pervasive developmental disorders
GROUP BENEFIT CHANGES	
City of Allen Park	Effective July 1, 2013, Medicare-eligible retirees of the City of Allen Park 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 26488 with suffix 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**.
City of Farmington	Effective July 1, 2013, Medicare-eligible retirees of the City of Farmington 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 60245 with suffix 600. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PPO plan, go to **bcbsm.com/provider/ma**.

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BENEFIT POLICY continued from Page 13

GROUP BENEFIT CHANGES	
City of Farmington Hills	Effective July 1, 2013, Medicare-eligible retirees of the City of Farmington Hills will have Blue Cross Blue Shield of Michigan's Medicare Advantage PDP plan, Prescription Blue PDP℠. The group number is 60253 with suffixes of 600, 601, 602, 603, 604 and 605. 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**.
Genesee District Library	Effective July 1, 2013, Medicare-eligible retirees of Genesee District Library 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 60250 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**.
Macomb County	Effective July 1, 2013, Medicare-eligible retirees of Macomb County 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 59905 with suffix 602. 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**.
Sheet Metal Local 7 Zone 3	Effective July 1, 2013, Medicare-eligible retirees of Sheet Metal Local 7 Zone 3 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 60247 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**.

BCBSM prenotification system training materials available July 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.

BCBSM will upgrade the prenotification system the weekend of Aug. 9-11. We ask that hospitals do not submit prenotifications during this testing weekend. Hospitals may begin using the system with its new features Aug. 12.

BCBSM will initially release an online computer-based training course in mid-July via web-DENIS. Hospitals will be able to view this CBT at their own pace.

BCBSM will also host two online question and answer sessions the last week of July. Providers will receive an invitation to online Q&A sessions in mid-July. Hospitals should designate at least one representative who will be using the prenotification system on a regular basis to attend a Q&A session.

Prenotification system training materials will address overall functionality, including all major enhancements and required fields, such as diagnosis narrative, subset, inpatient criteria met or not met, and physician overrides. For details on prenotification system enhancements, see the May issue of *The Record*.

For technical assistance, call the web-DENIS Help Desk at 1-877-258-3932. Please contact your BCBSM facility provider consultant with all other questions.

Bill hospital-based office visits on professional claims

As part of the Hospital Outpatient Pricing Strategy, Blue Cross Blue Shield of Michigan will no longer make separate facility payments for select office services.

BCBSM has instructed hospitals to bill hospital-based office visit services only on professional claims. An additional change is that BCBSM has made the facility and non-facility rates the same for those services.

BCBSM will pay the following evaluation and management procedure codes at the non-facility rate, regardless of setting.

E&M codes for office visits (HCPCS procedure codes):

*99201-*99205
*99211-*99215
*99381-*99387
*99391-*99397

Do **not** bill members for the facility portion of the visit, as the full payment will be made on the professional claim.

BCBSM changes emergency room, trauma services billing

Effective Oct. 1, 2013, BCBSM will process and make separate payments for evaluation and management services received in emergency room or trauma settings when a surgical service is provided in the same visit. This change to processing and payment is part of our ongoing Hospital Outpatient Pricing Strategy Project that we have mentioned in previous articles.

The corresponding ER and trauma evaluation and management procedure codes are: *99281-*99285, *99291, *99292 and G0390. The changes include dates of service on or after Oct. 1, 2013.

The following are sample claims illustrating how services should be billed:

HOPS EMERGENCY continued on Page 16

HOPS EMERGENCY continued from Page 15

Example 1: All services provided on one date

UB-04 CLAIM EXAMPLE FOR REPORTING EMERGENCY ROOM AND TRAUMA SERVICES WITH LINE ITEM DATE OF SERVICE PROCESSING

1 MEMORIAL HOSPITAL	2	3a PAT CNTL # 44440	4 TYPE OF BILL
1818 FINE ST		b. MED REC #	0131
WONDERLAND MI 48235		5. FED TAX NO.	6 STATEMENT COVERS PERIOD FROM 100113 THROUGH 100113
313-787-5542		123456789	7

8. PATIENT NAME a VALUED CUSTOMER		9. PATIENT ADDRESS a 8087 CIRCLE	
b		b	c d e

10. BIRTHDATE	11. SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16. DHR	17. STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29. ACDT. STATE	30
01011961	F			1	1		01			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

	39. CODE	VALUE CODES AMOUNT		40. CODE	VALUE CODES AMOUNT		41. CODE	VALUE CODES AMOUNT	
a	A3	9935	00						
b									
c									
d									

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES/HIPPS CODE	45. SERV. DATE	46. SERV UNITS	47. TOTAL CHARGES		48. NON-COVERED CHARGES		49.
1	0250	PHARMACY	90XXX		3	150	00			
2	0270	MED-SUR SUPPLIES	Q4XXX		1	257	00			
3	0300	LABORATORY	88XXX		1	92	00			
4	0300	LABORATORY	88XXX		1	56	00			
5	0300	LABORATORY	88XXX		1	25	00			
6	0300	LABORATORY	88XXX		1	45	00			
7	0360	OR SERVICES	21XXX		1	2500	00			
8	0390	BLOOD STORAGE	86XXX		1	60	00			
9	0391	BLOOD ADMINISTRATION	36XXX		1	300	00			
10	0450	EMERGENCY ROOM	99XXX		1	2500	00			
11	0682	EMERGENCY ROOM/TRAUMA	99XXX		1	3650	00			
12	0710	RECOVERY			1	300	00			
22										
23		*PAGE_____ OF _____*	*CREATION DATE*		*TOTALS* a	9935	00			

HOPS EMERGENCY continued on Page 17

HOPS EMERGENCY continued from Page 16

Example 2: Services provided span more than one day

UB-04 CLAIM EXAMPLE FOR REPORTING EMERGENCY ROOM AND TRAUMA SERVICES WITH LINE ITEM DATE OF SERVICE PROCESSING

1 MEMORIAL HOSPITAL	2	3a PAT CNTL # 44440	4 TYPE OF BILL
1818 FINE ST		b. MED REC #	0131
WONDERLAND MI 48235		5. FED TAX NO.	6 STATEMENT COVERS PERIOD FROM 100113 THROUGH 100313 / 7
313-787-5542		123456789	

8. PATIENT NAME	a VALUED CUSTOMER	9. PATIENT ADDRESS	a 8087 CIRCLE
b		b	c d e

10. BIRTHDATE	11. SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16. DHR	17. STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29. ACDT. STATE	30
01011961	F			1	1		01													

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

	39. CODE	VALUE CODES AMOUNT	40. CODE	VALUE CODES AMOUNT	41. CODE	VALUE CODES AMOUNT
a	A3	3122 00				
b						
c						
d						

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES/HIPPS CODE	45. SERV. DATE	46. SERV UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
1	0250	PHARMACY	90XXX	100113	3	150 00		
2	0260	IV THERAPY	96XXX	100113	1	79 00		
3	0300	LABORATORY	89XXX	100113	1	92 00		
4	0305	LAB/HEMATOLOGY	85XXX	100113	1	45 00		
5	0305	LAB/HEMATOLOGY	85XXX	100313	1	45 00		
6	0306	LAB/BAC-MICRO	87XXX	100213	1	40 00		
7	0450	EMERGENCY ROOM	99XXX	100113	1	990 00		
8	0730	EKG	93XXX	100213	1	66 00		
9	0762	OBSERVATION ROOM	G0XXX	100213	18	1615 00		
10								
11								
12								
22								
23		*PAGE_____ OF _______*	*CREATION DATE*		**TOTALS** a	3122 00		

Physical, occupational, speech therapy billing changes Oct. 1

Beginning Oct. 1, 2013, BCBSM will have new billing requirements for hospital outpatient departments and freestanding outpatient physical therapy facilities for physical, occupational and speech therapy services.

Here are the changes:

- Value code 80 is no longer required.
- Series billing is no longer required.
- Line item reporting of PT, OT and ST revenue and HCPCS codes is effective for dates of service Oct. 1, 2013, and later.

This claim example below illustrates the way charges should be billed for outpatient physical therapy, occupational therapy and speech therapy in a freestanding outpatient physical therapy facility or hospital outpatient location, effective Oct. 1, 2013.

UB-04 CLAIM EXAMPLE FOR REPORTING SERVICES WITH LINE ITEM DATE OF SERVICE PROCESSING SHOWING BILLING FOR GROUP THERAPY SERVICES

1	2	3a PAT CNTL #	44440		4 TYPE OF BILL
MEMORIAL HOSPITAL		b. MED REC #			0131
1818 FINE ST		5. FED TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
WONDERLAND MI 48235		123456789	100113	100813	
313-787-5542					

8. PATIENT NAME	a	VALUED CUSTOMER	9. PATIENT ADDRESS	a	8087 CIRCLE
b			b	c	d e

10. BIRTHDATE	11. SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16. DHR	17. STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29. ACDT. STATE	30
01291948																				

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
29	100113	35	100113	44	100813	45	100813							

	39. CODE	VALUE CODES AMOUNT	40. CODE	VALUE CODES AMOUNT	41. CODE	VALUE CODES AMOUNT
a	A3	449 00				
b						
c						
d						

	42. REV. CD.	43. DESCRIPTION	44. HCPCS/RATES/HIPPS CODE	45. SERV. DATE	46. SERV UNITS	47. TOTAL CHARGES	48. NON-COVERED CHARGES	49.
1	0421	PHYSICAL THERAPY VISIT	97014	100113	1	30 00		
2	0421	PHYSICAL THERAPY VISIT	97150	100113	2	80 00		
3	0421	PHYSICAL THERAPY VISIT	97140	100813	2	100 00		
4	0431	OCCUPATIONAL THERAPY VISIT	97114	100813	1	64 00		
5	0431	OCCUPATIONAL THERAPY VISIT	97140	100813	2	100 00		
6	0441	SPEECH THERAPY VISIT	92508	100813	1	75 00		
7								
8								
9								
10								
11								
22								
23		PAGE_____ OF _______	CREATION DATE		TOTALS a	449 00		

Revenue code 0255 won't be added to IVT-chemo category

BCBSM previously communicated in the November 2012 *Record* that revenue code 0255, pharmacy drugs incidental to radiology, would be added to the IVT-chemotherapy category as part of the Hospital Outpatient Pricing Strategy changes that take effect Oct. 1, 2013. We've determined that it will not be added to that category, but will remain in the radiology category.

Ambulatory infusion centers should apply now to participate

As we reported in the February and May issues of *The Record*, ambulatory infusion centers that want to contract with Blue Cross Blue Shield of Michigan and Blue Care Network can apply online to participate with the Blues, effective Aug. 1, 2013.

AICs — which provide patients with additional safe, convenient, cost-effective locations to receive infusion therapy — must participate in order to receive reimbursement from us. Submit your enrollment form as soon as possible to ensure the application is processed in time for the effective date.

Please remember, physicians should 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 the Ambulatory Infusion Centers Enrollment Forms page**.**
- Complete the *BCBSM/BCN New Facility Enrollment Form* online and print it.
- Read the BCBSM agreement and signature document, and then print the signature document and sign it.
- Fax both the form and the signature document according to the instructions on the form.

Note: Participating AICs that will submit claims electronically need to register with BCBSM EDI after July 1, 2013. For additional information about electronic billing registration, please call the EDI Helpdesk at 1-800-542-0945.

AICs with other questions about contracting with the Blues should contact their provider consultants as follows:

BCBSM Provider Relations
Southeast Michigan — 313-225-7778
Western Michigan — 616-389-8141
Mid-Michigan — 517-325-4590

Not in the Physician Group Incentive Program? Here's your chance to join

You have an opportunity to help change the face of health care in Michigan. Join Blue Cross Blue Shield of Michigan's Physician Group Incentive Program.

Known as PGIP, this innovative program is helping improve the quality, value and efficiency of health care in the state. It has been developed with input from physicians across Michigan and facilitates change through a wide variety of initiatives and rewards to physician organizations for improving health care delivery.

Applications for new participants are being accepted July 1 through Aug. 30, 2013.

Requirements
Physicians must join PGIP through a physician organization. To be eligible to join PGIP, each organization must:

- Be a partnership, association, corporation, individual practice association or other legal entity with its own taxpayer identification number
- Be able to receive and distribute income among its members
- Be composed of 75 or more Blues participating physicians, with 50 of those physicians practicing as primary care providers (internal medicine, pediatrics, family practice or general practice)
- Have contractual authority to represent its physicians for this program
- Be able to coordinate and facilitate practice improvements and program administration on behalf of its member physicians

Physicians are limited to participation with only one physician organization for the purposes of PGIP.

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We must receive completed applications by Friday, Aug. 30, 2013.

For more information:

- If you represent a physician organization and would like to complete an application to join PGIP, email the Value Partnerships staff at providerpartnerships@bcbsm.com.
- If you are an individual practitioner with questions about participating in PGIP, contact your provider consultant.

To learn more about PGIP, check **bcbsm.com** and the Value Partnerships website or contact your provider consultant.

Not sure who your provider consultant is?

1. Go to **bcbsm.com/provider** and click on *Help Center.*
2. Click on *Contact Us.*
3. Under Physicians and Professionals, click on *Blue Cross Blue Shield of Michigan provider contacts.*
4. Click on your region *(Mid-Michigan, Southeast Michigan, Upper Peninsula or West Michigan).*

Documentation guidelines for physicians and other professional providers updated

Revised signature requirements, including those for Centers for Medicare & Medicaid Services, were recently incorporated into document guidelines and provider manuals for physicians and other providers. Here's an overview of the updates.

Medical record entries
Each entry, such as verbal orders and instructions, prescriptions and telephone consultations, must include:

- The date the information is documented and the specific time when relevant.
- A legible signature that can be easily authenticated. Blue Cross Blue Shield of Michigan accepts written (cursive or printed) and electronic signatures. Stamped signatures are not acceptable.
    - For electronic signatures, the system must authenticate the signature at the end of each note. An acceptable electronic signature includes a lead-in phrase, such as, "electronically signed by," "authenticated by," "approved by," "completed by," "finalized by" or "validated by," followed by the provider's name, credentials and the date signed. The process must be password protected and used exclusively by the individual physician.
- Credentials, like M.D. or D.O., should be written after a provider's name unless his or her credentials are included on the stationery of the accompanying note.

Note: All providers of mental health and substance abuse services must include their credentials (for example, John Smith, Ph.D.). Other physicians (who don't provide mental health and substance abuse services) are not required to include credentials.

Medical record pages

- Each page of a medical record, including test data and reports, must include patient identification, either the patient name or provider-designated patient ID number.
- All diagnostic imaging must include unique patient identification and the date of service as a permanent part of the image.

The documentation guidelines can be found in your provider manuals in the chapter titled "Documentation Guidelines" and also on web-DENIS. We'll notify you about future guideline updates in *The Record* and on web-DENIS.

If you have any questions, contact your provider consultant.

Clarification: Letter explaining patient charges for preventive visits is optional tool for offices

In response to questions we've received from some health care providers, we're clarifying the intent of the patient letter template explained in the March *Record* article titled, "Letter explains patient charges for preventive visits that include medical treatment."

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

Use of this letter template regarding preventive and medical billing is entirely optional. BCBSM's reason for developing the letter was to offer a way for providers to cut down on patient confusion and questions about the billing of medical versus preventive services.

Providers who decide to use the letter are encouraged to customize the text to fit their individual needs.

Subscribe to electronic physician newsletter

Did you know that Blue Cross Blue Shield of Michigan has a monthly newsletter designed especially for physicians?

It's called *Physician Update*, and it includes information on key BCBSM initiatives, tools to help you enhance your practice and tips for making it easier to do business with us. Here's a look at the kind of information you'll find in the newsletter:

- An inside look at how we're transforming health care in the state through programs such as the Physician Group Incentive Program and Organized Systems of Care
- Information on industry trends, including health care reform and value-based contracting, and how they impact you as a participating BCBSM physician
- Tools you may want to use in your practice, ranging from downloadable brochures on medication safety to guidelines that help you discuss end-of-life planning with patients
- Columns on timely topics from BCBSM staff physicians, including Dr. Thomas Simmer, Dr. David Share, Dr. George Kipa, Dr. Jean Malouin and Dr. Beth Goldman

To subscribe, go to **bcbsm.com/providers**:

- Click on the *Newsletters* tab.
- Select *Overview*.
- Click on the *subscribe* link at the top of the page.

Physician Update can also be accessed via a mobile device.

All prescriptions must be signed by licensed prescribers

Please remember that all prescriptions must be signed by licensed prescribers, as outlined in the Blue Cross Blue Shield of Michigan and Blue Care Network provider participation agreements. According to Michigan law, licensed prescribers include: medical doctors, doctors of osteopathy, doctors of dental surgery, doctors of podiatric medicine or optometrists (in limited instances).

Medical doctors or doctors of osteopathic medicine and surgery are allowed to delegate prescriptive authority to other licensed health care professionals who have the requisite education, training or experience. Delegates must be supervised by the M.D. or D.O. The name of the supervising physician and the delegated prescriber must both appear on the prescription.

According to Michigan law, supervision must include direct communication, regular and direct consultation and predetermined procedures and drug protocols.

SIGNATURE REQUIREMENT continued on Page 22

PROFESSIONAL, PHARMACY

SIGNATURE REQUIREMENT continued from Page 21

The following is key information about delegate eligibility:

- **Physician assistants and nurse practitioners:** Prescriptions signed by physician assistants and nurse practitioners are presumed valid because they are assumed to have delegated prescriptive authority.
- **Registered nurses and registered pharmacists:** It cannot be assumed that registered nurses and registered pharmacists have been properly delegated prescriptive authority.
- **Licensed practical nurses and medical assistants:** These professionals do not possess the requisite education, training or experience to be delegated prescriptive authority or are not licensed by the state. Therefore, they are not eligible for delegated prescriptive authority.

To ensure a prescription is valid prior to filling it, pharmacists are obligated to properly scrutinize and question prescriptions that appear to be executed by someone other than a licensed prescriber.

Follow prescription signature guidelines for controlled, noncontrolled substances

Recent audits have revealed that a rising number of prescriptions do not meet the prescription signature guidelines required by Blue Cross Blue Shield of Michigan and Blue Care Network. In order to determine what signatures are acceptable for controlled and noncontrolled substances, you should ascertain how the prescription originated and then how it was received.

Stamped signatures are not allowed. The chart below provides guidelines to help you understand the Blues' signature documentation requirements for a valid prescription.

Following an audit, BCBSM and BCN will seek recovery, including statistical projection, for claims that are not supported by prescriptions meeting these requirements. For additional information on prescription signatures, see *The Record's* May 2009 article titled "Drug program signatures."

Prescription signature guidelines

	Traditional paper prescription	Prescription sent from prescriber fax to pharmacy fax	Prescription sent from prescriber computer to pharmacy fax	Prescription sent from prescriber computer to pharmacy computer
Noncontrolled Substances	Physical signature	Physical signature	Electronic signature	Electronic signature
Controlled Substances	Physical signature	Physical signature CIII-CV only	Not applicable, this transmission option is not permitted	Electronic signature, when legal requirements are satisfied (e.g. certification)

PHARMACY

Crestor® tier status changing on custom drug list

As part of our ongoing efforts to promote cost-effective, high-quality prescription drug therapy, Crestor® will become nonpreferred on the *Blue Cross Blue Shield of Michigan and Blue Care Network Custom Formulary*.

This change, which is effective July 1, 2013, doesn't apply to members with BCN Advantage℠, Blue Cross Complete of Michigan or Blue Cross Medicare Part D. Affected members were notified by letter in late May. Blues customers with a two-tier closed drug benefit who are currently on Crestor can continue therapy with their current copayment and, therefore, didn't receive a letter.

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Other members with a two-tier closed drug benefit will be required to obtain a medical necessity authorization before they can receive Crestor. Members enrolled in a three-tier drug benefit will be charged a nonpreferred-brand copayment.

In our letters to customers, we encouraged them to contact their physicians to discuss other treatment options, including atorvastatin (Lipitor®), lovastatin (Mevacor®), pravastatin sodium (Pravachol®) and simvastatin (Zocor®).

To view our drug lists:

1. Go to **bcbsm.com.**
2. Click on *Help.*
3. Click on *Plan Documents and Forms*.
4. Scroll down to Pharmacy and click on *Drug Lists.*

If you have any questions about our pharmacy programs, call the Pharmacy Services Clinical help desk at 1-800-437-3803 and select option 1.

Be aware of quantity limits for diabetic supplies

Blue Cross Blue Shield of Michigan has classified procedure codes A4230, A4231 and A4232 as diabetic supply procedure codes. These procedures can be performed every 90 days. However, there is a yearly quantity limit for all members, with the exception of MESSA and FEP members. .

See the following chart to determine the quantity maximum per year.

Procedure codes	Quantity
A4230	Maximum of 300 per year
A4231	Maximum of 300 per year
A4232	Maximum of 720 per year

As always, be sure to check group-specific benefits and quantity maximums.

Please note: Diabetic supplies for FEP members are handled by Caremark.

Health e-Blue℠ offers new Diagnosis Evaluation tool

As announced in the May 2013 *Record*, a new Diagnosis Evaluation report is available on Health e-Blue℠. We urge primary care physicians to review this report for their Blues Medicare Advantage patients and take action to close any diagnosis gaps.

More information is available in the Resources section of Health e-Blue by clicking on *2013 Diagnosis Closure Incentive Program*.

Frequently asked questions
A new Medicare Advantage Diagnosis Closure Incentive Program frequently asked questions document is available in the Resources section of Health e-Blue, as well as within web-DENIS. Here's how to find the new FAQ in web-DENIS:

1. Click on *BCBSM Provider Publications and Resources*.
2. Click on *Newsletters and Resources*.
3. Click on *Medicare Advantage Resources*.
4. Look under *What's New*.

If you have any questions about the new incentive program or the new Health e-Blue report, please contact your BCBSM provider consultant.

Contact Medicare Advantage Provider Inquiry regarding human organ transplant procedures

We're providing you with a new contact for questions about Blue Cross Blue Shield of Michigan human organ transplant procedures covered by our Medicare Plus Blue PPO℠ and Medicare Plus Blue Group PPO℠ products.

Our Human Organ Transplant Program is no longer managing transplant benefits for our Medicare Advantage members. If you have questions about the benefit, you should now call the Blue Cross Medicare Advantage Provider Inquiry department at 1-866-309-1719. This transition occurred on June 1, 2013.

It's also important to note:

- Each relevant transplant procedure must be performed in a Medicare-approved facility.
- Medicare Advantage members aren't required to use Blue Distinction Centers® for Transplant. Also, that designation doesn't guarantee Medicare approval.
- Preauthorization isn't required for transplant procedures covered by Original Medicare or by optional, enhanced Medicare Plus Blue Group PPO benefits.
- For case management help, transplant facilities should refer Medicare Advantage members to the Blue Cross Case Management Program by calling 1-800-845-5982.

Helping members manage transplant procedures
The following information will help you talk with patients about Blue Cross human organ transplant procedures:

- Members with coverage questions about transplant procedures should call the Customer Service number on the back of their ID cards.
- Medicare Advantage groups have the option of purchasing enhanced organ transplant coverage that involves diagnoses and procedures that may not be covered in Original Medicare. Medicare Advantage group members should refer to their *Evidence of Coverage* or contact Customer Service to find out if they have expanded coverage.
- Some Medicare Advantage group members have coverage for travel and lodging related to transplant services. Customer Service can also provide information about that benefit.
- A member's cost-sharing amount is determined by the group. All services must be provided during the benefit period, except for anti-rejection drugs and other transplant-related prescription drugs. The benefit period begins five days before the transplant and ends one year after the transplant.

When directly related to a covered transplant, Medicare Advantage will pay for anti-rejection drugs and other transplant-related prescription drugs — during and after the benefit period. For noncovered transplants, the member's prescription drug plan is responsible for anti-rejection drugs and other transplant-related prescription drugs.

If you would like more information about procedures included in the enhanced transplant benefit, visit BCBSM's Newsletters & Resources Medicare Advantage Resources page.
Here's how to find it:

1. Go to **bcbsm.com**.
2. Click on LOGIN and select *Provider*.
3. Log in to *Provider Secured Services.*
4. Click on *web-DENIS.*
5. Click on *BCBSM Provider Publications and Resources.*
6. Click on *Newsletters & Resources.*
7. Click *on Medicare Advantage.*
8. Click on *Human organ transplants: Enhanced benefit transplant procedures.*

The countdown to ICD-10 continues

By now, everyone knows that the federal government is requiring the health care industry to begin using ICD-10 codes in place of ICD-9 codes beginning Oct. 1, 2014. The transition is a big change for all those in the industry who use these codes, but the hope is that using ICD-10 will help everyone to:

- Better measure health care services
- Improve health monitoring
- Provide better data
- Decrease the need for additional claim documentation

As we get closer and closer to the transition date, we will publish more information about transition tips, deadlines, ICD-10 news and notes, testing information and upcoming seminars and training sessions.

Be sure to check ***The Record*** for more information or go online to **cms.gov/icd10** and **bcbsm.com/icd10**.

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
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Provider Inquiry

If you're calling from this area code (professional)

248, 313, 586, 734, 810 or 947	1-800-245-9092
517, 989	1-800-272-0172
231, 269, 616, *989	1-800-255-1878
906	1-866-872-5837
Outside Michigan	1-800-482-3146
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248, 313, 517, 586, 734, 810, 947 or 989	1-800-228-4599 (hospitals) 1-800-437-3804 (facilities)
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Provider Consulting Services, Manager's Office

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

Provider Contracting (facility)

1-800-777-2118

providercontracting@bcbsm.com

Provider Enrollment and Data management (professional)

1-800-822-2761

Physician Ombudsman office

1-800-816-BLUE (2583)

Other valuable contact information

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

Electronic Claims Submission

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

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