August 2013

Articles in this issue…

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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 August issue on July 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*.
- Click on *Newsletters 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

Changes coming as Blue Cross Blue Shield of Michigan transitions to nonprofit mutual

As we told you about earlier this year, Gov. Rick Snyder signed Public Acts 4 and 5, the acts that enable BCBSM to begin its transition to become a nonprofit mutual insurer. During this process, we promised our health care providers that we would keep them informed of progress and any changes that could occur as a result of the transition.

Progress to date

- The transition is ongoing throughout 2013, and BCBSM will complete the transition by Jan. 1, 2014.
- The process of creating a new company and governance is being led by BCBSM's board of directors.
- Internal teams are reviewing the Michigan Insurance Code, which will regulate us moving forward (like all other insurers in Michigan).
- Operational and business changes to operate as a nonprofit mutual company are underway and minimal.

What isn't changing

- Our current health care coverage for your Blue Cross patients and our ongoing partnerships with physicians and hospitals to improve the quality of care
- Our core values as a nonprofit with a deep commitment to Michigan and our customers
- Our contributions to building a healthier future for Michigan

What will be different

- Provider class plans and their annual reporting will no longer be required.
  - BCBSM will continue to contract, set fees and policies, and regularly review performance based on provider groupings and types.
  - This is similar to the provider classes established through the Public Act 350.
- Some of our contracts include language regarding provider appeals under PA350, and this will change.
- The appeals process

A closer look at the appeals process

- Under the Michigan Insurance Code, the Department of Insurance and Financial Services will no longer review provider appeals for audit and post-service claim determinations.
- In order to be compliant with the insurance code, the BCBSM appeals process no longer includes DIFS.
- The proposed process replaces DIFS or binding arbitration with an external peer review by an independent review organization for non-policy (medical or clinical) issues.
- The results of the external peer review will be binding on both parties.
- All providers will continue to have access to their current internal appeal process.

These changes will continue to be communicated in *The Record* and on web-DENIS, but they must be reviewed and approved through our board of directors. As a result, we will publish an official notification of changes in the October issue of *The Record.*

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

Health care reform corner: A look at essential health benefits

The basics
Part of the Affordable Care Act is the requirement that small group and individual plans cover essential health benefits. Included are things like screenings for cancer and diabetes, vaccinations and chronic health condition management. A plan's coverage of essential health benefits is one factor in determining if it is a qualified health plan under the Affordable Care Act.

What are the essential health benefits?
Essential health benefits fall into these categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

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NHR continued from Page 2

- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Habilitative and rehabilitative services and devices
- Laboratory services
- Preventive and wellness services, and chronic disease management
- Pediatric vision and dental services

What isn't considered an essential health benefit?

There are several benefits that fall into this category:

- Non-covered procedures per BCBSM's medical policy
- Voluntary termination of pregnancy
- Gender reassignment surgery
- Radial keratotomy
- Chemical peel for acne
- Private-duty nurse
- Special foods for inherited metabolic diseases of childhood
- Artificial insemination

Who gets these benefits?

The essential health benefit requirement applies to non-grandfathered individual plan members and small group plan members for 2014. To be sure that BCBSM's plans are compliant with the Affordable Care Act, we needed to make sure that our new plans in 2014 for individuals and small groups met this requirement.

When will the benefits be available to patients?

The benefits take effect with the plan year effective date. It may or may not be in the first part of 2014. It's extremely important that you continue to check your patients' benefits and eligibility on web-DENIS or CAREN.

What about cost-sharing?

In some cases, the benefits are available with no cost-sharing (deductible, copay, coinsurance) requirements. In other cases, there is a cost-sharing requirement that ends once the member reaches the out-of-pocket maximum. Again, it's extremely important that you check benefits, eligibility and status of cost-sharing on web-DENIS or CAREN.

For more information about health care reform, go to **bcbsm.com**. For benefits and eligibility questions, check web-DENIS or call CAREN.

New, improved and easy bcbsm.com gives members info about their coverage, cost-sharing and more

As part of an ongoing series of improvements, the **bcbsm.com** member site was recently overhauled to help members gain a greater understanding of their health plan information. These enhancements translate into knowledgeable patients spending less time at your reception desk with questions about their Blues plans, and allowing you more quality time to spend with them.

We announced these improvements as part of a statewide campaign launched this summer to encourage Blues members to register on the new site in order to take advantage of its innovative features.

Once members log in to **bcbsm.com**, they'll have instant access to their personal health information and a wealth of features, including:

- **Personal snapshot of their plan:** The new member site provides your Blues patients with an easy-to-understand snapshot of their deductibles, coinsurance, recent claims activity and other important cost information to help them know what they owe.

- **24/7 mobile access:** We've made it easy for your patients to access plan information through their mobile devices, 24 hours a day, seven days a week. Now, if members forget to bring their ID cards to an appointment, they can access their own virtual ID card right in your office from a mobile device.

  With immediate access to their health plan information, Blues patients can answer many of their own questions about deductibles, claims or cost information – anytime, anywhere.

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- **Powerful doctor and hospital search capabilities:** We've made it easier for members to locate a doctor or hospital with our enhanced Find a Doctor tool.

  Members can now search by location, doctor, specialty, network and more, as well as evaluate up to six doctors or hospitals side-by-side, comparing quality and costs for hundreds of services across the country.* Later this year, we'll include a tool that can estimate out-of-pocket costs specific to a member's health plan before they even step foot into your office. Members can also read reviews about specific doctors and leave reviews of their own.

  The enhanced *Find a Doctor* tool, with its new comparison and review features, could bring additional patients, as well as those more suited to your specialty, through your door.

If you'd like more information for your Blues patients, please contact your provider consultant. We'll continue to inform our members as we release more enhancements to the site.

*Cost information for PPO members only.

Keep these coding tips in mind to improve medical record documentation

Diabetes is one of the most common and costly conditions in the U.S. This complex disease causes long-term complications affecting the renal, nervous and peripheral vascular systems, as well as the feet and eyes. According to 2012 Centers for Disease Control and Prevention statistics, diabetes continues to be the leading cause of kidney failure, nontraumatic lower-extremity amputations and blindness among adults ages 20 to 74.

It's no surprise that documentation and coding for this complicated condition is a challenge to both health care providers and coders. Here are some tips to help improve medical record documentation for diabetes.

Common documentation and coding challenges for diabetes mellitus:

- Documentation does not support a link between diabetes to its associated complications and manifestations.
- A less specific diabetes code is reported when documentation supports a specific diabetic condition that has associated manifestations.
- The associated manifestation or "buddy" code is not reported in addition to primary diabetes code.
- Electronic medical record search engines may provide long lists of codes for diabetes, making selection of the most specific diagnosis code a challenge.
- Electronic billing systems limit number of diagnoses for patients with multiple diabetes manifestations and chronic conditions.

Diabetes has several subcategories, but the most basic subcategory is code 250.0X, for diabetes without associated manifestations. If manifestations due to diabetes are present, the appropriate subcategory should be reported. The fourth digit indicates the type of manifestation.

250.0X	Diabetes mellitus without mention of complication **(no manifestation)**
250.4X	Diabetes with **renal** manifestations
250.5X	Diabetes with **ophthalmic** manifestations
250.6X	Diabetes with **neurological** manifestations
250.7X	Diabetes with **peripheral** circulatory disorders
250.8X	Diabetes with **other** specified manifestations
250.9X	Diabetes with **unspecified** complication

These codes require a fifth digit to communicate if the diabetes is Type I or Type II, and if the diabetes is controlled or uncontrolled.

0	Type II or unspecified type, not stated as uncontrolled
1	Type I (juvenile type), not stated as uncontrolled
2	Type II or unspecified type, uncontrolled
3	Type I (juvenile type) uncontrolled

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Additional coding tips

- Document whether the diabetes is Type I or Type II every time you treat the patient. Documentation of insulin usage alone does not support a diagnosis of Type I diabetes. If the type of diabetes is not documented, then use the unspecified code, Type II.
- Indicate whether the diabetes is controlled or uncontrolled. **Note:** This can't be inferred from lab results; it must be stated in the documentation. Per coding guidelines, "poor control" should be coded as controlled.
- Assign code V58.67 for patients that use insulin to control their diabetes. This code shouldn't be assigned if insulin is only given temporarily to bring a patient's blood sugar under control during an encounter.
- Assign a code from category 249.XX, secondary diabetes, when diabetes is caused by another condition or event such as cystic fibrosis, malignant neoplasm of the pancreas, pancreatectomy or adverse effect of drug or poisoning. Check ICD-9-CM guidelines for sequencing rules.
- Assign code 648.8X for gestational diabetes and report code 648.0X for obstetric patients with pre-existing diabetes. Additional codes from the 250 or 249 category should be assigned to indicate the type of diabetes.
- Many patients will have manifestations in more than one subcategory. Assign as many subcategory codes as needed to communicate the complexity of a patient's condition.
- Report code 996.57 for underdose or overdose of insulin due to insulin pump failure. For insulin overdose, report additional code 962.3 for insulin poisoning. Next, report appropriate codes from category 250 or 249.
- Use concise words and abbreviations in EMR search engines for help in coding diabetes to the highest specificity. For example, searching for "dm with renal" or "retinopathy due to dm" instead of "diabetes mellitus" could yield a shorter and more specific list of code choices.

Next month's *Record* article on coding tips will explore coding diabetes manifestations for renal, ophthalmic, neurological and peripheral circulatory disorders.

Coordination of benefits process modified for some UAW members

Effective Aug. 1, 2013, some UAW and UAW Retiree Medical Benefits Trust members who are eligible for the Major Medical program will receive new ID cards.

The cards will indicate that the members have Master Medical coverage, giving health care providers an easy way to identify that a medical claim can be submitted for these patients. The group number affected is 70605.

Previously, these members had to submit documentation to the UAW Employee Benefits & Pensions Department to be reimbursed for any coinsurance or deductibles they paid for medical services.

Reminder: BCBSM does not provide benefits for experimental or medically unnecessary services

Please remember that Blue Cross Blue Shield of Michigan does not provide benefits for experimental or medically unnecessary procedures, treatments, drugs or devices.

Health care providers may not bill members for such services unless they:

1. Give a cost estimate of the services.
2. Have the member confirm in writing that he or she assumes financial responsibility and that BCBSM will not make a payment.

These statements are required before services are rendered.

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	
81599, 0005M** **Use procedure code 0005M after July 1, 2013.	**Basic Benefit and Medical Policy** Nucleic acid sequencing-based testing of maternal plasma for trisomy 21 may be considered established in women with high-risk singleton pregnancies undergoing screening for trisomy 21, effective May 1, 2013. Karyotyping would be necessary to exclude the possibility of a false positive nucleic acid sequencing-based test. Before testing, women should be counseled about the risk of a false positive test. Nucleic acid sequencing-based testing of maternal plasma for trisomy 21 in women who do not meet the above criteria is considered experimental. **Group Variations** Excludes Chrysler, Delphi, Ford, General Motors and UAW Retiree Medical Benefits Trust groups. **Inclusionary Guidelines** High-risk singleton pregnancies, as defined by the American College of Obstetricians and Gynecologists Committee Opinion, Number 454, December 2012 include women who meet at least one of the following criteria:. · Maternal age 35 years or older at delivery · Fetal ultrasonographic findings indicating increased risk of aneuploidy **Continued on next page**

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NEW PAYABLE PROCEDURES

81599, 0005M**

**Use procedure code 0005M after July 1, 2013.

Continued

- History of previous pregnancy with a trisomy
- Standard serum screening test positive for aneuploidy
- Parental balanced robertsonian translocation with increased risk of fetal trisomy 13 or trisomy 21
- Nucleic acid sequencing-based testing of maternal plasma for trisomy 21 with confirmatory testing of positive results using karyotyping in high-risk pregnant women with singleton pregnancies

Exclusionary Guidelines

- Women with singleton pregnancies at average and low risk
- Nucleic acid sequencing-based testing of maternal plasma for trisomy 21 in women with twin multiple gestations pregnancies
- DNA-based sequencing methods for detection of trisomy 13 and 18

UPDATES TO PAYABLE PROCEDURES

77520, 77522, 77523, 77525

Revenue code 0333

Basic Benefit and Medical Policy
The safety and effectiveness of charged-particle irradiation with proton or helium ion beams have been established. It may be considered a useful therapeutic option when indicated for patients who meet the patient selection criteria and for the indications listed in the inclusions section, effective March 1, 2013.

Proton beam therapy for all other indications, including localized prostate cancer and non-small-cell lung cancer at any stage or for recurrence, is experimental.

Group Variations
The auto groups and URMBT will be communicating their benefit decision separately.

Payment Policy
Proton treatment delivery is payable to a facility only. Professional services should be submitted with an appropriate clinical treatment planning procedure code.

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.

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UPDATES TO PAYABLE PROCEDURES	
77520, 77522, 77523, 77525 Revenue code 0333 ***Continued***	· 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. **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.
A9900, E0955-E0957, E0960, E2601-E2617, E2620-E2625, K0108, K0669	**Inclusionary Guidelines** A general use seat cushion (E2601,E2602) and a general use wheelchair back cushion (E2611-E2612) is covered for a patient who has a manual wheelchair or a power wheelchair with a sling or solid seat or back that meets BCBSM coverage criteria. If the patient does not have a covered wheelchair, then the cushion will not be covered. If the patient has a POV or a power wheelchair with a captain's chair seat, the cushion will not be covered. For patients who meet coverage criteria for a power wheelchair and who do not have special skin protection or positioning needs, a power wheelchair with captain's chair provides appropriate support. Therefore, if a general use cushion is provided with a power wheelchair with a sling or solid seat or back instead of a captain's chair, the wheelchair and the cushion(s) will be covered if either criterion 1 or criterion 2 is met: 1. The cushion is provided with a covered power wheelchair base that is not available in a captain's chair model – i.e., procedure codes K0839, K0840, K0843, K0860-K0864, K0870, K0871, K0879, K0880, K0886, K0890, K0891. 2. A skin protection or positioning seat or back cushion that meets coverage criteria is provided. If one of these criteria is not met, both the power wheelchair with a sling or solid seat and the general use cushion will not be covered. If the patient has a POV or a power wheelchair with a captain's chair seat, a separate seat or back cushion will not be covered. A skin protection seat cushion (E2603, E2604, E2622, E2623) is covered for a patient who meets both of the following criteria: **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES

A9900, E0955-E0957, E0960, E2601-E2617, E2620-E2625, K0108, K0669

Continued

1. The patient has a manual wheelchair or a power wheelchair with a sling or solid seat or back and the patient meets the BCBSM coverage criteria for it.
2. The patient has either of the following:
   a. Current pressure ulcer (ICD-9-CM codes lower back, hip, buttock) or past history of a pressure ulcer (lower back, hip, buttock) on the area of contact with the seating surface.
   b. Absent or impaired sensation in the area of contact with the seating surface or inability to carry out a functional weight shift due to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia (quadriplegia unspecified and C1-C4 complete); other spinal cord disease (syringomyelia and syringobulbia, vascular myelopathies, subacute combined degeneration of spinal cord in diseases classified elsewhere, myelopathy in other diseases classified elsewhere); multiple sclerosis; other demyelinating disease; neuromyelitis optica; Schilder's disease; acute (transverse) myelitis; acute (transverse) myelitis NOS; acute (transverse) myelitis in conditions classified elsewhere; idiopathic transverse myelitis; other demyelinating diseases of central nervous system; demyelinating disease of central nervous system, unspecified); cerebral palsy (diplegic, hemiplegic, quadriplegic, monoplegic, infantile hemiplegia, other specified infantile cerebral palsy, unspecified infantile cerebral palsy); anterior horn cell diseases, including amyotrophic lateral sclerosis; Werdnig-Hoffmann disease; spinal muscular atrophy; spinal muscular atrophy, unspecified; Kugelberg-Welander disease, other; motor neuron disease; amyotrophic lateral sclerosis; progressive muscular atrophy; pseudobulbar palsy; primary lateral sclerosis, other; other anterior horn cell diseases; anterior horn cell disease, unspecified); post-polio paralysis (late effects of acute poliomyelitis); traumatic brain injury resulting in quadriplegia, other; spina bifida (spina bifida with hydrocephalus, unspecified region; spina bifida with hydrocephalus, cervical region; spina bifida with hydrocephalus, dorsal (thoracic) region; spina bifida with hydrocephalus, lumbar region; spina bifida without mention of hydrocephalus,

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UPDATES TO PAYABLE PROCEDURES	
A9900, E0955-E0957, E0960, E2601-E2617, E2620-E2625, K0108, K0669 ***Continued***	unspecified region; spina bifida without mention of hydrocephalus, cervical region; spina bifida without mention of hydrocephalus, dorsal [thoracic] region; spina bifida without mention of hydrocephalus, lumbar region); childhood cerebral degeneration (leukodystrophy, cerebral lipidoses, cerebral degeneration in generalized lipidoses, cerebral degeneration of childhood in other diseases classified elsewhere, other specified cerebral degenerations in childhood, unspecified cerebral degeneration in childhood); Alzheimer's disease; Parkinson's disease (paralysis agitans); muscular dystrophy (congenital hereditary muscular dystrophy, hereditary progressive muscular dystrophy); hemiplegia (flaccid hemiplegia affecting unspecified side, flaccid hemiplegia affecting dominant side, flaccid hemiplegia affecting nondominant side, spastic hemiplegia, spastic hemiplegia affecting unspecified side, spastic hemiplegia affecting nondominant side, other specified hemiplegia, other specified hemiplegia affecting dominant side, other specified hemiplegia affecting nondominant side, unspecified hemiplegia, unspecified hemiplegia affecting dominant side, unspecified hemiplegia affecting nondominant side, hemiplegia affecting unspecified side, hemiplegia affecting dominant side, hemiplegia affecting nondominant side); Huntington's chorea; idiopathic torsion dystonia (genetic torsion dystonia); athetoid cerebral palsy. A positioning seat cushion (E2605, E2606), positioning back cushion (E2613-E2616, E2620, E2621) and positioning accessory (E0955-E0957, E0960) is covered for a patient who meets both of the following criteria: 1. The patient has a manual wheelchair or a power wheelchair with a sling or solid seat or back and the patient meets BCBSM coverage criteria for it. 2. The patient has any significant postural asymmetries that are due to one of the diagnoses listed in criterion 2b above or to one of the following diagnoses: monoplegia of the lower limb (affecting unspecified side, affecting dominant side, affecting nondominant side) due to stroke, **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
A9900, E0955-E0957, E0960, E2601-E2617, E2620-E2625, K0108, K0669 ***Continued***	traumatic brain injury or other etiology; spinocerebellar disease (Friedreich's ataxia, hereditary spastic paraplegia, primary cerebellar degeneration, other cerebellar ataxia, cerebellar ataxia in diseases classified elsewhere, other spinocerebellar diseases, spinocerebellar disease, unspecified); above-knee leg amputation (unilateral, at or above knee, without mention of complication; unilateral, at or above knee, complicated; unilateral, level not specified, without mention of complication; unilateral, level not specified, complicated; bilateral [any level], without mention of complication, bilateral [any level], complicated); osteogenesis imperfect; transverse myelitis (other causes of myelitis). A headrest (E0955) is also covered when the patient has a covered manual tilt-in-space, manual semi- or fully reclining back on a manual wheelchair, a manual fully reclining back on a power wheelchair or power tilt or recline power seating system. If the patient has a POV or a power wheelchair with a captain's chair seat, a headrest or other positioning accessory will not be covered. A combination skin protection and positioning seat cushion (E2607, E2608, E2624, E2625) is covered for a patient who meets the criteria for both a skin protection seat cushion and a positioning seat cushion. If a skin protection seat cushion, positioning seat cushion or combination skin protection and positioning seat cushion is provided and if the stated coverage criteria are not met, it will not be covered. If a positioning back cushion is provided for a patient who does not meet the stated coverage criteria, it will not covered. If a positioning accessory is provided and the criteria are not met, the item will not be covered. A custom fabricated seat cushion (E2609) is covered if criteria (1) and (3) are met. A custom fabricated back cushion (E2617) is covered if criteria (2) and (3) are met: 1. Patient meets all of the criteria for a prefabricated skin protection seat cushion or positioning seat cushion. 2. Patient meets all of the criteria for a prefabricated positioning back cushion. **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
A9900, E0955-E0957, E0960, E2601-E2617, E2620-E2625, K0108, K0669 ***Continued***	3. There is a comprehensive written evaluation by a licensed or certified medical professional, such as a physical therapist or occupational therapist, which clearly explains why a prefabricated seating system is not sufficient to meet the patient's seating and positioning needs. The PT or OT may have no financial relationship with the supplier. If a custom fabricated cushion is provided for a patient who does not meet the stated coverage criteria, it will not be covered. A seat or back cushion that is provided for use with a transport chair (E1037, E1038) will not be covered. The effectiveness of a powered seat cushion (E2610) has been established. A prefabricated seat cushion, a prefabricated positioning back cushion, or a brand name custom fabricated seat or back cushion that does not meet the criteria stated in the BCBSM inclusionary coverage guidelines will not be covered. When billing for a custom fabricated cushion (E2609, E2617), the claim must include the manufacturer and model name or number of the product (if applicable), or if not, a detailed description of the product that was provided.
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0271-E0274, E0280, E0290-E0297, E0301-E0305, E0310, E0315, E0316, E0328, E0329, E0910-E0912, E0940	**Inclusionary Guidelines** Effective May 1, 2013, BCBSM has adopted Medicare's policies for hospital beds. Medicare has the following criteria for a fixed hospital bed (E0250, E0251, E0290, E0291 and E0328) to be covered. They must have one or more of the following criteria for the service: 1. The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head or upper body less than 30 degrees does not usually require the use of a hospital bed. 2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain. 3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out. 4. The patient requires traction equipment that can only be attached to a hospital bed. **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0271-E0274, E0280, E0290-E0297, E0301-E0305, E0310, E0315, E0316, E0328, E0329, E0910-E0912, E0940 ***Continued***	BCBSM has adopted Medicare's criteria for the variable hospital beds. A variable height hospital bed (E0255, E0256, E0292 and E0293) is covered if the patient meets one of the criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position. BCBSM has adopted Medicare's criteria for the following criteria for the semi-electric hospital beds. A semi-electric hospital bed (E0260, E0261, E0294, E0295 and E0329) is covered if the patient meets one of the criteria for a fixed height bed and requires frequent changes in body position or has an immediate need for a change in body position. BCBSM has adopted Medicare's criteria for the heavy duty extra wide hospital bed. A heavy duty extra wide hospital bed (E0301, E0303) is covered if the patient meets one of the criteria for a fixed height hospital bed and the patient's weight is more than 350 pounds, but does not exceed 600 pounds. BCBSM has adopted Medicare's criteria for the following criteria for an extra heavy-duty hospital bed (E0302, E0304) is covered if the patient meets one of the criteria for a hospital bed and the patient's weight exceeds 600 pounds. BCBSM has adopted Medicare's criteria for a total electric hospital bed (E0265, E0266, E0296 and E0297) is not covered; the height adjustment feature is a convenience feature. Total electric beds will be denied as not reasonable and necessary. BCBSM has adopted Medicare's criteria for the following statement for any of the above hospital beds and procedure code E1399, if documentation does not justify the medical need of the type of bed billed, payment will be denied as not reasonable and necessary. If the patient does not meet any of the coverage criteria for any type of hospital bed it will be denied as not reasonable and necessary. **Hospital Bed Accessories** BCBSM has adopted Medicare's criteria for the following hospital bed accessories: · Trapeze equipment (E0910, E0940) is covered if the patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed. **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
E0250, E0251, E0255, E0256, E0260, E0261, E0265, E0266, E0271-E0274, E0280, E0290-E0297, E0301-E0305, E0310, E0315, E0316, E0328, E0329, E0910-E0912, E0940 ***Continued***	· Heavy duty trapeze equipment (E0911, E0912) is covered if the patient meets the criteria for regular trapeze equipment and the patient's weight is more than 250 pounds. · A bed cradle (E0280) is covered when it is necessary to prevent contact with the bed coverings. · Side rails (E0305, E0310) or safety enclosures (E0316) are covered when they are required by the patient's condition and they are an integral part of, or an accessory to, a covered hospital bed. · A replacement innerspring mattress (E0271) or foam rubber mattress (E0272) is covered when they are required by the patient's condition for a patient owned hospital bed.
L3250	**Inclusionary Guidelines** Prosthetic shoes (L3250) are covered if they are an integral part of prosthesis for patients with a partial foot amputation for the following diagnosis: · Congenital transverse deficiency of lower limb · Congenital longitudinal deficiency, tarsals or metatarsals, complete or partial (with or without incomplete phalangeal deficiency) · Congenital longitudinal deficiency, phalanges, complete or partial · Traumatic amputation of toe(s) (complete) (partial), without mention of complication · Traumatic amputation of toe(s) (complete) (partial), complicated · Traumatic amputation of foot (complete) (partial) · Traumatic amputation of foot (complete) (partial), unilateral, without mention of complication · Traumatic amputation of foot (complete) (partial), unilateral, complicated · Traumatic amputation of foot (complete) (partial), bilateral, without mention of complication · Traumatic amputation of foot (complete) (partial), bilateral, complicated When billing for prosthetic shoes (L3250) and related items, an ICD-9 diagnosis code (specific to the fifth digit), describing the condition which necessitates the prosthetic shoes, must be included on each claim for the prosthetic shoes and related items.

BENEFIT POLICY continued on Page 9

BENEFIT POLICY continued from Page 11

POLICY CLARIFICATIONS	
90849, G9012, H0031, H0032, H2019	The effectiveness of applied behavior analysis in the treatment of autism spectrum disorder has been established. It may be a useful therapeutic option when inclusionary and certificate guidelines are met. This policy is effective July 1, 2013. Refer to member's certificate for benefit specific coverage guidelines. **Inclusionary Guidelines** · Full diagnostic criteria for autism spectrum disorder, as published in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual," are met. · The maladaptive behavior must impact the child's personal safety, the safety of others within the child's environment, or must significantly interfere with the child's ability to function. · Services must be provided by or supervised by a therapist who is certified by the Behavior Analyst Certification Board. · There is a treatment plan that: - Is child-centered - Defines target behaviors - Records objective measures of baseline levels and progress - Identifies and documents specific interventions and techniques - Documents transitional and discharge plans **Exclusionary Guidelines** · People who do not meet the diagnostic criteria based on the most recent criteria by the American Psychiatric Association (e.g., the most current version of the Diagnostic and Statistical Manual). · Therapy delivered by clinicians who are neither certified by the Behavior Analyst Certification Board nor supervised by therapists with this certification · Therapy for people older than 18

BENEFIT POLICY continued on Page 16

ALL PROVIDERS

BENEFIT POLICY continued from Page 15

GROUP BENEFIT CHANGES	
City of Taylor	Effective Aug. 1, 2013, Medicare-eligible retirees of the City of Taylor will have an additional option for its Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, covering its medical, surgical and prescription drug benefits. The group number is 59819 with suffix 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.**
Mt. Morris Charter Township	Effective Aug. 1, 2013, Medicare-eligible retirees of the Mt. Morris Charter Township will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for its medical, surgical and prescription drug benefits. The group number is 60256 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.**

PROFESSIONAL

Additional specialty types to become eligible for fee uplifts

As part of the continuing development of the Physician Group Incentive Program and Organized Systems of Care, 17 additional specialty types will be eligible for fee uplifts, effective Feb. 1, 2014. This brings the number of eligible specialty types to 24.

The specialist fee uplifts are designed to reward specialists for partnering with a community of caregivers as patient-centered medical home "neighbors" to provide high quality, cost-effective care for a shared population of patients. The patient-centered medical home neighbor, or PCMH-N, concept introduced by the American College of Physicians outlines principles to promote improved coordination between PCMH and specialty practices.

Below is a complete list of the eligible specialty types:

- Allergy
- Cardiology
- Chiropractic
- Critical care
- Endocrinology
- Emergency medicine
- Gastroenterology
- Infectious disease
- Neonatal care
- Nephrology
- Neurology
- Obstetrics and Gynecology
- Oncology
- Orthopedics
- Otolaryngology
- Pain management
- Physical medicine
- Podiatry
- Psychiatry
- Psychology
- Pulmonology
- Rheumatology
- Sports medicine
- Urology

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Only specialists who are PGIP members and who participate through a PGIP physician organization as of Aug. 1, 2013, are eligible for the 2014 fee uplifts. The specialist practice units must be nominated by their member PO and, in some cases, another physician organization with which the practice shares a substantial number of patients. Nominated specialists are evaluated for the fee uplifts based on quality, cost, utilization and efficiency measures at a population level.

Eligibility for the specialist fee uplifts is determined on an annual basis. We encourage each practitioner who is not yet a member of PGIP to:

- Reach out to a physician organization he or she feels best represents their natural community of caregivers.
- Discuss PGIP with his or her provider consultant and begin a conversation about fee uplift eligibility for 2015.

Members of PGIP with questions about the fee uplifts should consult with their POs.

BCBSM measures, promotes clinical effectiveness for mental health

Blue Cross Blue Shield of Michigan is committed to improving the quality of mental health treatment delivered to our customers. For that reason, we encourage physicians to follow treatment standards developed by the Michigan Quality Improvement Consortium and one additional standard developed by BCBSM. We are also tracking some aspects of care quality by using measures within the Healthcare Effectiveness Data and Information Set, or HEDIS.

MQIC has two guidelines directed to mental health concerns, including:

- The *Primary Care Diagnosis and Management of Adults with Depression Guideline* addresses key components of detection and diagnosis using validated screening tools (PHQ-2 and PHQ-9) and DSM-IV (Diagnostic and Statistical Manual, 4th edition, American Psychiatric Association) criteria. It includes recommendations in screening for suicidal risk and management of patients on antidepressant medication. (The latter includes conditions in which referral to a behavioral health specialist is advised.)
- The *Screening, Diagnosis, and Referral for Substance Use Disorders Guideline* should be followed at every health maintenance exam or initial pregnancy visit, and also includes the HEDIS standards of treatment initiation and follow-up within 14 and 30 days, respectively. The MQIC guidelines may be viewed at **MQIC.org**.

Blue Cross Blue Shield of Michigan's clinical practice guideline on Diagnosis and Management of Attention Deficit Hyperactivity Disorder is a useful summary of the core symptoms leading to detection and diagnosis, elements of nonpharmacological management and proper initiation of pharmacotherapy (beginning with stimulants as first line therapy), as well as common comorbid conditions frequently seen with adult ADHD. This guideline may be found on web-DENIS in the online provider manuals, "Best Practices" chapter.

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

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

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

Reminder: Blues offering webinars on professional coding

If you haven't yet attended one of the Blues seminars on professional coding, there's still time.

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

We encourage you to participate in one of the webinars listed below. In addition to providing you with information on professional coding, the webinars will give you the chance to ask questions of certified coders.

Here's a list of the remaining seminars that BCBSM is hosting throughout 2013:

Date	Time
Tuesday, Aug. 13	12-1 p.m.
Wednesday, Aug. 21	9-10 a.m.
Wednesday, Aug. 28	9-10 a.m.
Wednesday, Sept. 4	12-1 p.m.
Wednesday, Sept. 11	9-10 a.m.
Tuesday, Sept. 17	12-1 p.m.
Thursday, Sept. 26	12-1 p.m.
Tuesday, Oct. 1	9-10 a.m.
Wednesday, Oct. 9	9-10 a.m.
Wednesday, Oct. 16	9-10 a.m.
Wednesday, Oct. 23	12-1 p.m.
Tuesday, Oct. 29	9-10 a.m.
Wednesday, Nov. 6	9-10 a.m.
Wednesday, Nov. 13	9-10 a.m.
Wednesday, Nov. 20	9-10 a.m.
Tuesday, Dec. 3	9-10 a.m.
Wednesday, Dec. 11	9-10 a.m.

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

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

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

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

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

Please contact your provider consultant if you have any questions related to the webinars or computer-based training.

MMBA schedules ICD-10 classes

The Michigan Medical Billers Association will host a two-day class focusing on the guidelines and documentation principles for ICD-10 in September 2013. The classes will be held at two locations and are open to members and non-members.

Dates and locations

Sept. 11-12
Soaring Eagle Casino
6800 Soaring Eagle Blvd.
Mt. Pleasant

Sept. 18-19
Ukrainian Cultural Center
26601 Ryan Road
Warren

For more details, please go to **mmbaonline.org/the-guidelines-and-principles-of-icd-10-cm-for-coders/***. If you have any questions, call the MMBA at 1-888-314-2025 or send an email to info@mmbaonline.org.

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

Blues begin contracting with ambulatory infusion centers

Physicians now have another option to consider when deciding where to refer patients for infusion therapy.

Blue Cross Blue Shield of Michigan is formally contracting with ambulatory infusion centers, effective Aug. 1, 2013. We've been accepting applications from AICs interested in contracting with the Blues since May.

BCBSM and BCN decided to contract with qualified ambulatory infusion centers to provide our members with additional safe, convenient, cost-effective locations to receive infusion therapy. Please keep the following in mind:

- Home infusion therapy providers that have infusion suites will need to register as AICs to be reimbursed for services provided in the infusion suites. You may continue to provide home infusion therapy under your current HIT agreement.
- Hospital-based ambulatory infusion therapy facilities are not required to register as AICs. Hospitals may elect to enroll their AICs or they can continue to be reimbursed under the Participating Hospital Agreement.

AICs will be included in the provider directory on **bcbsm.com** by the end of the month. In the short term, we'll include a list of the participating AICs on our website. From the **bcbsm.com** homepage, click on *Find a Doctor* and scroll down to "Additional Directories."

To help ensure that your patients have the lowest possible out-of-pocket costs, you'll want to refer them to in-network AICs or other participating health care providers that offer infusion therapy services. AICs must participate with us to receive reimbursement.

Note: The benefit policies for Ford and UAW Retiree Medical Benefits Trust members currently do not include coverage for services provided by AICs. These members can continue to receive infusion therapy at hospitals, physician offices or from participating home infusion therapy providers.

If you know of an AIC that may be interested in participating with the Blues, direct them to the provider section of our website at **bcbsm.com/providers**.

- Click on *Sign up today*.
- Click on *Provider Enrollment.*
- Follow the prompts to access the AICs Enrollment Form.

If you have any questions, contact your provider consultant.

Facility hospice training classes scheduled

Blue Cross Blue Shield of Michigan has scheduled two facility hospice training classes for the 2013 calendar year.

The classes were designed to offer a clear and simple overview of the hospice billing procedures and guidelines. They'll also provide an overview of web-DENIS features that will assist you in navigating through our online manual.

To help make the class a success, we're asking you to submit your questions in advance. You can submit your questions online when you register or send them to your provider consultant.

You have two dates to choose from:

- Monday, Aug. 19, 2013
- Thursday, Oct. 31, 2013

Here's other information you'll need to know:

- Classes will run from 9 a.m. to noon. They may extend later or end earlier, depending on participant questions.
- Both classes will be in the Midnight Training Room M at Lyon Meadows, 53200 Grand River Ave., New Hudson
- These sessions do not offer continuing education units and do not include clinically specific subject matter.
- You will not need to bring any additional reference materials or manuals.

To register, send an email to SEfacilityeducationregistration@bcbsm.com and indicate your name, facility and date of the class you wish to attend. You will receive a confirmation within 72 hours of registering. It's important to register so we may contact you in the event of a change or if the training is cancelled.

FACILITY

Reminder: 2013 Michigan hospital networking sessions

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

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

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

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

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

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

Discharge hour required on inpatient claims with frequency code 1, 4 and 7

Please remember that the discharge hour (Form Locator 16) is required on all final inpatient claims with frequency bill codes 1, 4 and 7 (Form Locator 04), except for skilled nursing facility inpatient claims, Type of Bill 021X. This change was effective on July 1, 2012, per the National Uniform Billing Committee.

This requirement is not applicable to hospice claims billed to BCBSM since they are excluded from the mandate.

AUTO GROUPS

Chrysler launches employee benefits program for treatment of autism

Chrysler Group LLC has created an Autism and Autism Spectrum Disorder Pilot Program for salaried employees and their eligible dependents.

The program, which took effect July 1, applies to workers who are Michigan residents enrolled in Chrysler's Blue Cross Blue Shield of Michigan Healthy Blue Choices℠. It offers benefit coverage for applied behavior analysis treatment and other autism services that are rendered by a Michigan-based provider.

Letters were sent to employees in June notifying them of the pilot program and associated benefit changes.

Important things to know about the program:

- Chrysler employees will be subject to copayments, as well as deductibles and coinsurance.
- All eligible dependents will have their ABA treatment, psychotherapy and nutritional counseling covered. They qualify for the program until they turn 19; when they reach that age, their benefits will expire at the end of their birth month.
- ValueOptions, which handles Chrysler's mental health services, will coordinate benefits. ABA providers who currently have Chrysler clients will need to call 1-800-346-7651 to set up a discussion with Value Options' Provider Relations department.

Chrysler is also expanding coverage for physical, occupational and speech therapies used to treat ASD and congenital and severe developmental disorders.

There are a few provisions:

- Eligible dependents can only receive speech therapy services until the end of the month in which they turn 7.
- A maximum of 100 speech therapy visits will be covered, but there is no limit on physical and occupational therapy sessions.
- Claims for physical, speech and occupational therapies that date back to Jan. 1, 2013, will be reprocessed.

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CHRYSLER continued from Page 20

The pilot program complies with Michigan's Autism Insurance Reform legislation and is expected to last until the end of 2014.

TheraMatrix begins administering physical therapy services for some non-Michigan UAW members

Effective July 1, 2013, TheraMatrix is administering outpatient physical therapy services for General Motors hourly UAW Traditional Care Network PPO members outside of Michigan.

TheraMatrix started administering outpatient physical therapy services for Michigan-based members in July 2012. Covered physical therapy evaluation and treatment includes CPT codes *97001, *97002, modalities *97010 through *97799, and revenue codes 420, 421 and 424 in approved office and outpatient settings.

Claims for these services provided to non-Michigan residents on or after July 1, 2013, should be submitted to:

TheraMatrix Physical Therapy Network
P.O. Box 321036
Detroit, MI 48232-1036

All **inpatient** facility physical therapy and inpatient or outpatient occupational or speech therapy services are excluded from this program. Blue Cross Blue Shield of Michigan will process claims for such services. BCBSM will also process claims for physical therapy services received in the emergency room or during an observation stay.

Call 1-888-638-8786 or visit **theramatrix.com**** if you have questions about eligibility, coverage or benefits.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2012 American Medical Association. All rights reserved.

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State's group vision plan offers exception for patients with changed eyeglass prescriptions

The State of Michigan group vision plan normally provides benefit coverage for a patient's new eyeglass lenses and frames every 24 months. However, if it's determined that there has been a change in an eyeglass prescription, the patient's new lenses and frames are eligible for coverage every 12 months.

For electronic claim submissions, providers should indicate that there has been a change in the prescription in the designated area on the 837 claim record. Paper claim submissions sent to Blue Cross Blue Shield of Michigan should include a copy of the prescription, or they should include supporting documents that indicate there has been a change in the prescription.

Please submit paper claims to:

Blue Cross Blue Shield of Michigan
Mail Code L07A
232 S. Capital Ave.
Lansing, MI 48933

Or fax paper claims to:

1-866-238-3645

(Note: The fax cover letter should indicate that it is a SOM vision prescription change request.)

Benefit coverage for eyeglass lenses and frames

- **Vision exams:** One every 12 months (must be performed by an optometrist or ophthalmologist)
- **Lenses and frames:** One set every 24 months (or one set every 12 months if a prescription changes)

Blue Cross Blue Shield of Michigan issues Medicare Advantage claim overpayment reports

After reviewing its records, Blue Cross Blue Shield of Michigan determined that it overpaid some Medicare Advantage providers for services provided to BCBSM Medicare Advantage members. Providers who are affected will receive a letter with more details.

This overpayment occurred on our former claims processing system, PGBA, and will be transferred to our new claims processing system, ikaSystems. Affected providers will receive a PGBA claim overpayment information sheet that includes the recovery amount and the members who received services.

The ikaSystems remittance will deduct any claim overpayments, which may result in no payment or a reduced payment in the future. If any money is owed to you, it will be included in your notification or sent separately. We'll also include a current remittance that details current claims payment information from ikaSystems.

We apologize for any inconvenience this may cause. If you have any questions, call our Medicare Advantage Provider Inquiry department at 1-866-309-1719 between 8 a.m. and 4:30 p.m., Monday through Friday.

To review our recovery and provider disputes process in more detail, visit the Overpayment Page on our provider website at **bcbsm.com/provider/ma**.

- Click on *Medicare Plus Blue PPO*.
- Click on *Provider Toolkit*.
- Click on *Overpayment* under the Billing and Payment header.

Following is overview of the information the report contains. (See the screen shot on the next page.)

1. Tax ID: The Tax ID used to match the PGBA overpayment with the ikaSystems check
2. Provider name: The provider name associated with the overpayment
3. National provider identifier: The NPI associated with the overpayment
4. Claim number: PGBA claim number associated with the overpayment
5. Original amount owed: The original amount of the overpayment
6. Refund reason code: The reason for the overpayment
7. Subscriber name: Patient name related to the overpayment
8. Subscriber contract number: Patient contract number with BCBSM Medicare Advantage
9. Patient control number: Patient account number submitted by the provider
10. Begin date of service: Beginning date of service on the overpayment
11. End date of service: Ending date of service on the overpayment
12. Total charge: The total charged amount on the overpayment
13. Accounts receivable number: Unique number related to the overpayment
14. Date created: The date the overpayment was identified
15. Date received: The date the payment was offset or the check was received from the provider
16. Amount received: The amount applied to the overpayment
17. Check number: The check number of the offset amount or the check received from the provider
18. Check Source:
    a. Ika – New system offset
    b. PGBA – Old system offset
    c. Provider – Check received from the provider
19. Totals by tax ID:
    a. Total original amount owed – Total of all claims original amount overpaid
    b. Total amount received – Total of all amounts received as of the date of the statement
    c. Remaining balance owed – The balance of the overpayment the provider still owes BCBSM
20. Total checks offset this statement:
    a. Check number – Check number used for the overpayment
    b. Check amount – Total check amount
    c. Check date – The date of the check
    d. Check source – The system the check was generated from
    e. Amount offset for Accounts Receivable – Amount of check taken for overpayments
    f. Remaining check balance – Any amount of the check due to the provider

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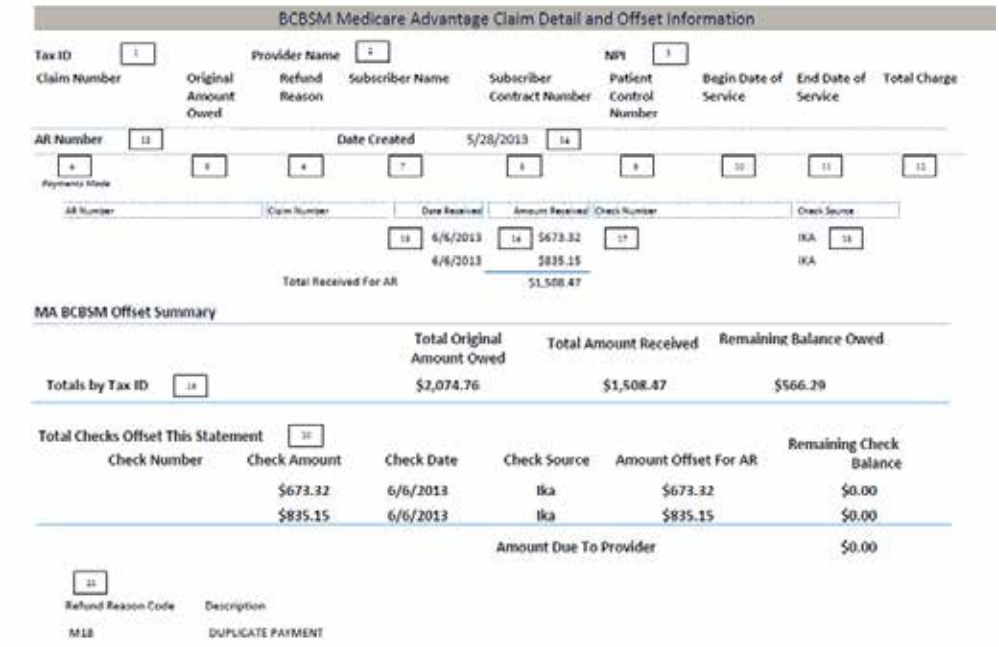
SOM VISION continued on Page 23

21. Refund reason code description – Detailed description of the overpayment



BCBSM Medicare Advantage Claim Detail and Offset Information

Tax ID [1] Provider Name [2] NPI [3]

Claim Number	Original Amount Owed	Refund Reason	Subscriber Name	Subscriber Contract Number	Patient Control Number	Begin Date of Service	End Date of Service	Total Charge
AR Number [13]			Date Created 5/28/2013 [14]					
[4] Payments Made	[5]	[6]	[7]	[8]	[9]	[10]	[11]	[12]

AR Number	Claim Number	Date Received	Amount Received	Check Number	Check Source
		[15] 6/6/2013	[16] $673.32	[17]	IKA [18]
		6/6/2013	$835.15		IKA
		Total Received For AR	$1,508.47		

MA BCBSM Offset Summary

	Total Original Amount Owed	Total Amount Received	Remaining Balance Owed
Totals by Tax ID [19]	$2,074.76	$1,508.47	$566.29

Total Checks Offset This Statement [20]

Check Number	Check Amount	Check Date	Check Source	Amount Offset For AR	Remaining Check Balance
	$673.32	6/6/2013	Ika	$673.32	$0.00
	$835.15	6/6/2013	Ika	$835.15	$0.00
			Amount Due To Provider		$0.00

[21]

Refund Reason Code	Description
M18	DUPLICATE PAYMENT

Reminder: Qualified Medicare beneficiaries can't be balance-billed for Medicare services

Keep in mind that qualified Medicare beneficiaries do not pay coinsurance or copayments for Medicare-covered services received from Medicare or Medicaid participating providers.

The state Medicaid program may pay for all or part of these cost-sharing amounts. All Medicare or Medicaid payments are considered full payments to providers.

Qualified Medicare beneficiaries are entitled to Medicare Part A and eligible for Medicare Part B. They have incomes below 100 percent of the federal poverty level and must be deemed eligible by their state Medicaid agency.

According to the August 2012 issue of *MLN Matters*, all Medicare physicians and suppliers who offer services or supplies to qualified Medicare beneficiaries cannot balance-bill those beneficiaries. This is explained in Section 1902 (n)(3)(B) of the Social Security Act as modified by Section 4712 of the Balanced Budget Act of 1997. Providers or suppliers who bill beneficiaries for Medicare cost-sharing are subject to sanctions.

Corporate Communications – MC 0245

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

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