September 2013

Articles in this issue…

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

When you subscribe, you'll receive the newsletter as an automatic email each month earlier than your printed edition reaches you. Blue Cross Blue Shield of Michigan typically sends the electronic *Record* on the last business day of the month. That means current subscribers should have received this September issue on Aug. 30.

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Detroit, MI 48226

Michigan to consolidate MIChild medical, pharmacy and vision coverage into MIChild plans operating as HMOs; Blue Dental℠ MIChild members to transition to other dental plans

The Michigan Department of Community Health is changing the MIChild program. Starting on Oct. 1, 2013, MDCH will begin to consolidate the medical, pharmacy and vision coverage of MIChild members into MIChild-approved HMO health plans. Most of these plans also offer Medicaid services through their HMO products. MIChild will remain a separate program from Medicaid with its own enrollment criteria and provider reimbursement. It will have the same MIChild benefit package currently available to members. MDCH has been interested in partnering with Medicaid HMO plans to streamline administration of government programs such as Medicaid and MIChild for a while.

MDCH is also moving all Blue Dental℠ MIChild members to other dental plans, effective Oct. 1, 2013.

MDCH has posted letters to medical, vision, pharmacy and dental care providers* on their website to make you aware of the transition. The letters have also been mailed.

How this affects Blue Cross' involvement in MIChild medical, pharmacy and vision coverage
Blue Cross' current MIChild plan offers PPO coverage rather than HMO coverage. Blue Cross PPO MIChild members will be transitioned into MIChild-approved HMO plans in phases.

The Blues remain committed to the MIChild population, and we are working with MDCH and other health plans to ensure a smooth transition for members over the next year. We will continue to provide PPO coverage to MIChild members until it's time for them to choose a MIChild-approved HMO plan. And in the future, our Medicaid HMO subsidiary, Blue Cross Complete, is planning to participate as a MIChild medical, pharmacy and vision coverage provider.

Here are the stages of MIChild member transition for medical, pharmacy and vision coverage:

- New MIChild enrollees (medical, pharmacy and vision) — New MIChild members in 34 counties (see list) will need to select a plan other than BCBSM after July 24. Their enrollment materials will no longer list BCBSM.
- Current BCBSM MIChild enrollees (medical, pharmacy and vision) — MIChild members who currently have Blue Cross coverage will transition to new MIChild HMO plans in stages.
    - The first group, comprising enrollees from 34 counties (see list below), will be transitioned to a new plan for Oct. 1, 2013. They will be notified by letter from MIChild scheduled for mailing on Aug. 28.
    - Enrollees who are renewing Sept. 1 will receive a separate renewal communication that does not list BCBSM.
- Other MIChild members outside these 34 counties who currently have Blue Cross coverage will be transitioned, county by county. MDCH will inform us in the future of this transition schedule. These enrollees will receive a MIChild letter when their county is transitioned, asking them to select a new plan.

The 34 counties that are part of the first transition of medical, pharmacy and vision coverage will involve all counties in the Upper Peninsula and some counties in the Lower Peninsula (listed below):

Alger	Kent	Newaygo
Arenac	Keweenaw	Oakland
Baraga	Lake	Oceana
Chippewa	Livingston	Ontonagon
Delta	Luce	Osceola
Dickinson	Mackinac	Otsego
Genesee	Macomb	Ottawa
Gogebic	Marquette	Schoolcraft
Houghton	Mason	Washtenaw
Ionia	Menominee	Wayne
Iosco	Montcalm	
Iron	Muskegon	

MDCH may add other counties to this first transition.

How this affects Blue Cross' involvement in MIChild dental coverage
MDCH is moving all Blue Dental℠ MIChild members to other dental plans, effective Oct. 1, 2013. We are working with MDCH to ensure a smooth transition for members.

MICHILD continued on Page 3

MICHILD continued from Page 2

Here are the stages of MIChild member transition for dental coverage:

- All Blue Dental℠ MIChild members will transition to other dental carriers. This change will occur on the same date for all members — Oct. 1, 2013. All enrollees will need to pick a new carrier before that date. Blue Dental enrollees will receive a letter from MIChild scheduled for mailing on Aug. 28.
- MIChild Blue Dental enrollees who renew on Sept. 1 will receive a separate renewal communication that does not list BCBSM.
- New MIChild dental enrollees will need to pick a carrier other than Blue Dental after July 24. Their enrollment materials will no longer list Blue Dental.

Participating with other MIChild insurers

If you want to offer medical, pharmacy, vision or dental care to MIChild members when they no longer have Blue Cross PPO or Blue Dental coverage, you must participate with a MIChild-approved HMO plan or dental carrier.

For the most up-to-date information on which plans are approved to provide MIChild coverage in each county, you can:

- Visit **michigan.gov/michild***.
  - Click on *MIChild Health Plan Service Contacts and Service Areas Listing* under *Info for MIChild Providers*.
- You can call also contact MIChild's Medical Services Administration Provider Support line at 1-800-292-2550 or email ProviderSupport@michigan.gov for this information or with any questions you may have.

Helpful documents

Log in to web-DENIS to see the letters sent by MDCH to providers about the changes to the MIChild program's medical, pharmacy, vision and dental coverage. You can also find answers to questions you may have as a Blue Cross PPO or Blue Dental provider on FAQs that we will update regularly with information as it becomes available. To find these documents:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- Click on *MIChild* to see the documents:
  - *MIChild letter from Michigan Department of Community Health*
  - *MIChild Provider FAQ*

Or see the latest issue of *Dental Care News* if you're a Blue Dental provider.

We recognize that you may have questions about this transition. Stay tuned for more information. We will update you regularly through web-DENIS and *The Record*.

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

New guidelines established for processing Medicare primary claims

Starting Oct. 13, 2013, Blue Cross Blue Shield of Michigan will change how Medicare primary claims are processed. The changes will align with the policies of the Blue Cross Blue Shield Association.

BCBSA requires a minimum 30-day waiting period after the Medicare remittance date before a Blues plan can accept or process provider-submitted supplemental claims that involve Medicare crossover.

Medicare primary claims are submitted to Medicare for processing and then forwarded to a secondary insurance carrier via a crossover arrangement for additional payment determinations.

Providers can identify Medicare crossover claims that have been sent to BCBSM by looking for remittance advice remark codes MA18 and N89.

As a result of the changes, we'll reject provider-submitted claims that include the following:

- They feature remark codes MA18 or N89, indicating that Medicare crossover occurred.
- They were received within 30 calendar days of the Medicare remittance date.

BLUECARD continued on Page 4

BLUECARD continued from Page 3

- They were received with no Medicare remittance date.
- They were received with a GY modifier on some lines, but not all. (The GY modifier is used to indicate that a code is statutorily excluded by Medicare.)

The new processing method for Medicare primary claims has additional guidelines. For statutorily excluded services and pricing issues with Medicare crossover claims, it's important to note:

- Providers who offer statutorily excluded services must indicate these services by using a GY modifier at the claim line level. This is a new requirement that will impact both professional and facility claims.
- Providers can only submit statutorily excluded service lines on a claim. They can't combine those lines with other services.
- If a provider submits a claim to Medicare with both paid and excluded lines, the home plans will deny the excluded lines on the crossover claims and instruct the provider to resubmit those lines to their local plan. (A home plan is the Blues plan in which the member is enrolled.)
- Providers will no longer have to submit known statutorily excluded services first to Medicare for consideration.
- Providers will submit statutorily excluded service claims directly to the host plan, which is the plan serving the area where the Blues member received health care services.

The Health Insurance Marketplace: A new way to shop and purchase health insurance

As part of the Affordable Care Act, consumers will be able to purchase health insurance from the Health Insurance Marketplace (formerly referred to as the Exchange), beginning in October. Coverage will be effective Jan. 1, 2014, and after.

Each state will have an opportunity to have its own Marketplace, either run by the state in partnership with the U.S. Department of Health and Human Services or independently by the state, according to federal and state laws governing health care. Michigan's Health Insurance Marketplace represents a partnership between the state and the federal government.

When launched, the Marketplace will enable consumers to compare prices and coverage between eligible insurance plans. This tool will allow consumers to select the plan that best suits their budget and their health care needs. Consumers will still be able to purchase health insurance coverage directly from health plans, such as Blue Cross Blue Shield of Michigan and Blue Care Network.

As a provider, odds are that your patients are going to treat you as a primary source of information regarding health care reform, especially the Marketplace. The following information is designed to help you answer some basic questions.

The Health Insurance Marketplace in a nutshell
The Health Insurance Marketplace is a website that will allow consumers to compare prices and coverage from different health plans that have met certain government requirements for eligibility in their area. Once a health plan is selected, consumers can either make their purchase through the Marketplace or continue to purchase health coverage directly from health plans.

The Marketplace opens Oct. 1, 2013, for the selection and purchase of health coverage that will be effective beginning Jan. 1, 2014. There will be two different Marketplaces:

- Individual Marketplace — For consumers purchasing coverage on their own
- Small Business Health Options Program, also known as SHOP — For businesses with 50 or fewer full-time-equivalent employees

Michigan's Health Insurance Marketplace will be located at **healthcare.gov***.

Requirements for health plans to be part of the Marketplace
Requirements vary from state to state, but there are a few important federal requirements that health plans must meet in order to be included on the Marketplace. Plans must offer comprehensive coverage, including preventive visits with no cost-sharing, essential health benefits (listed on next page) and prescription drug coverage. Plans eligible to participate in the Marketplace must follow limits on cost-sharing and other rules to receive certification as a qualified health plan.

NHR MARKETPLACE continued on Page 5

NHR MARKETPLACE continued from Page 4

Impact on the cost of health coverage
Qualified health plans on the Marketplace must state all costs up front, so consumers will know exactly how much they will be paying for coverage, and can select the plan that offers the best value for their situation. The Marketplace is expected to create open competition among insurance plans, which could result in lower prices for some plans.

How plans are organized on the Marketplace
Plans will be listed by the following categories: Bronze, Silver, Gold and Platinum. Catastrophic plans will also be offered. Bronze plans will offer coverage for the lowest monthly premium; deductibles, coinsurance and copayments will be higher than the other plans. The highest level plans, Gold and Platinum, have the highest monthly premiums; however, deductibles, coinsurance and copayments will be lower. Consumers will have to estimate how often they use health care to decide which plan is best for them. Catastrophic plans, with a very high deductible, will also be available to individuals.

Regardless of category, each plan must offer coverage for the following essential health benefits**:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health, substance abuse and behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services (including dental and vision care)

Health plans may impose cost-sharing on essential benefits, but must offer preventive care with no cost-sharing.

Cost-sharing structure:

- Bronze: pays approximately 60 percent of covered health care costs
- Silver: pays approximately 70 percent of covered health care costs
- Gold: pays approximately 80 percent of covered health care costs
- Platinum: pays approximately 90 percent of covered health care costs (available for small groups only)
- Catastrophic (for individuals only): Generally requires you to pay all medical expenses up to a certain amount. These plans usually have a high deductible.

Resources for those who struggle to afford health care
Some individuals will be able to get some kind of discount on costs for coverage at the Silver level, even those who were previously ineligible for assistance. There is a single, universal application on the Marketplace that anyone can fill out to see the discounts for which they are eligible.

There are two types of assistance available to those purchasing insurance through the Marketplace:

- Cost-share Reduction Subsidy — The federal government pays a portion of the consumer's cost-share, thereby reducing the deductible, copayments, coinsurance and out-of-pocket maximum costs for the member. This subsidy is based on household size and is only available to individuals who meet specific financial eligibility criteria (currently between 133* and 400 percent of the federal poverty level and who purchase a silver product through the Individual Marketplace.
- Advanced Premium Tax Credit Subsidy — The federal government pays a portion of the consumer's health care premium. This subsidy is only available to individuals who meet specific financial eligibility criteria (currently between 133* and 400 percent of the federal poverty level) and who purchase health coverage through the Individual Marketplace.

Note: Health insurance subsidies can be offered for people with incomes up to $94,200 for a family of four (based on 2013 figures).

*In Michigan, this could be lowered to 100 percent if the state of Michigan does not expand Medicaid coverage.

The information above is provided for informational purposes only. Providers do not need to do anything different for patients who receive subsidies.

NHR MARKETPLACE continued on Page 6

NHR MARKETPLACE continued from Page 5

Where consumers can get additional assistance
The Marketplace offers around-the-clock customer service representatives available to assist consumers with any questions. Call 1-800-318-2596.

Most consumers are eligible to use the Marketplace
As long as consumers live in the U.S., are U.S. citizens or nationals and are not currently incarcerated, they are eligible to use the Marketplace.

For more information on the Health Insurance Marketplace, please visit **healthcare.gov***.

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

Source: **healthpocket.com/affordable-care-act/essential-health-benefits

The information in this document is based on preliminary review of the national health care reform legislation and is not intended to impart legal advice. The federal government continues to issue guidance on how the provisions of national health reform should be interpreted and applied. The impact of these reforms on individual situations may vary. This overview is intended as an educational tool only and does not replace a more rigorous review of the law's applicability to individual circumstances and attendant legal counsel and should not be relied upon as legal or compliance advice.

Checking member eligibility, benefits is crucial under health care reform legislation

For years we've stressed the importance of checking member eligibility and benefits every time you provide services. With the implementation of health care reform, checking eligibility and benefits is even more crucial.

One reason is that we expect an influx of individual members. These are people who purchase their health care coverage directly from the Blues or through the individual Marketplace. These members will receive ID cards once they enroll, but their coverage will not become active until they pay their first month's premium and their effective date occurs.

Here are some important considerations:

- **Effective date** — In some cases, these individual members will have their ID cards a month or two before their effective dates. If they try to use their cards before their effective dates, they will not have coverage.
- **Premium unpaid** — If the member does not pay his or her first monthly premium, the coverage will not become effective. If the member pays the first payment but later becomes delinquent, coverage could cease. Keep in mind that there are special regulations regarding members with government-subsidized premiums. We will provide additional information in future issues about how to recognize members who are in delinquency, and recommendations on how to handle billing and payment for them.
- **Coverage changes** — A member can sign up for coverage but later change that coverage. Individual members can change coverage for any reason during the open enrollment period. For this first year of the Marketplace, the open enrollment period runs from Oct. 1, 2013, through March 31, 2014. After that, members with a qualifying event may still be able to change coverage. So a member may not keep coverage but could still present an ID card for services.

The bottom line is that possession of a Blues ID card does not necessarily mean the member has coverage that is currently in effect. While this has always been the case, you may find more situations in which ID cards are presented for coverage that is not in effect. Be aware that the Blues will not reimburse claims for services that are not in effect at the time of service.

As a reminder, there are three ways to check eligibility and benefits:

- Online using web-DENIS
- By calling our automated phone system, CAREN
- By calling Provider Inquiry

Keep in mind these coding tips to improve medical record documentation

This article is part of a series of coding tips that's running through the end of the year.

In the August edition of *The Record,* we discussed some common documentation and coding challenges for diabetes mellitus. Now, we'll take a closer look at documentation for renal, ophthalmic, neurological and peripheral circulatory manifestations of this complex condition.

Patients with diabetic manifestations often require more frequent and intensive care by health care providers, and the complexity of these patients' conditions is often not communicated accurately through documentation or coding. Following are some common errors and tips to keep in mind.

Common documentation and coding challenges for diabetic manifestations

- Documentation doesn't establish a link between the diabetes to its associated complications and manifestations.
- The note doesn't indicate how diabetes and its manifestations are managed, evaluated, assessed or treated by the provider.

Making the connection
A cause-and-effect relationship between diabetes and its manifestations should not be assumed. The relationship should be documented with correct linking words in the progress notes. For example:

- End stage renal disease **secondary to** diabetes
- Ulceration **caused by** diabetes
- Polyneuropathy **due to** diabetes
- **Diabetic** polyneuropathy

Incorrect linkage
Here's an example of an assessment with no established link between the diabetes, background retinopathy and Stage IV chronic kidney disease. The assessment doesn't indicate that retinopathy and CKD are manifestations of diabetes, so all conditions will need to be coded separately:

Assessment:

- Diabetes type II, controlled (250.00)
- Background retinopathy, stable (362.10)
- CKD stage IV, worsening (585.4)

Correct linkage
In contrast, the next documentation example links the manifestations to the diabetes, and the subcategories for ophthalmic and renal manifestations are reported, instead of 250.0X.

Note: The diabetes code (the cause) is sequenced first. The manifestation code (the effect) is sequenced second. Both codes are required to accurately report the condition.

Assessment:

- Background retinopathy **due to** Type II diabetes, controlled (250.50, 362.01)
- Stage IV CKD **caused by** Type II diabetes (250.40, 585.4)

Use of 'with' as a linking word
Many of the ICD-9-CM subcategory titles for diabetes use the word 'with' to express linkage between diabetes and the related manifestation, such as diabetes with renal manifestations. According to ICD-9-CM guidelines, the word 'with' should be interpreted to mean 'associated with' or 'due to' when it appears in the code title, the Alphabetic Index or an instructional note in the Tabular List of the ICD-9-CM.

Although the word 'with; is considered acceptable linkage within the context of the ICD-9-CM, BCBSM does not consider the word 'with' to be an acceptable linking word in provider documentation. The words 'secondary to,' 'caused by,' 'due to' or 'diabetic' show a stronger causality in documentation.

When a code is selected for an assessment, many electronic medical record systems automatically generate the ICD-9 subcategory description within the patient note. Use of only an ICD-9-CM subcategory title won't substantiate linkage for diabetes manifestations. Please use the appropriate linking words.

Manage, evaluate, assess or treat, also referred to as MEAT
Providers must clearly identify a patient's diagnosis in a progress note for an ICD-9-CM code to be valid. For example, 'diabetes type II, uncontrolled' cannot be coded if the only documentation is 'A1c of 9.9 and abnormal blood sugar of 284.' Additionally, the assessment and plan for each diagnosis should indicate how each condition was managed, evaluated, assessed or treated, and this information should be clearly connected to each individual diagnosis.

CODING TIPS continued on Page 8

CODING TIPS continued from Page 7

Manage: Indicate order of labs, diagnostic radiology or other tests

Evaluate: Document review of lab or X-ray results; summarize exam results

Assess: Describe the status of a patient's condition (stable, worsening or improved)

Treat: Indicate if medications are prescribed or refilled, surgical treatments, therapy services

Here's an example of how to properly code using the MEAT components:

Assessment and plan

1. Peripheral neuropathy caused by diabetes type II, uncontrolled (250.62, 357.2)
   Reviewed A1c, levels elevated at 11 percent
   Begin NPH insulin, 15 units SQ, per day
   Insulin education performed
   Refilled Topamax, 200 mg twice a day orally as needed for peripheral neuropathy

2. Benign hypertension, stable (401.1)
   Continue Diovan, 80 mg per day orally

It's important that each diagnosis is supported with clear linkage to the components of MEAT.

Mastering how to accurately document diabetes and its manifestations is the first step in coding for this complex condition.

Next month's article in this series will focus on code selection tips for diabetic manifestations.

Adhere to your filing limits and submit claims on time

We've been telling you that we're strictly enforcing claims filing limits, as of May 24, 2013.

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

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

Follow these guidelines:

- Deadline submissions for original claims remain the same — 180 days from the date of service for professional providers and 12 months from the date of service for facility providers.
- For secondary claims and status inquiries, the deadline is 24 months from the date of service.
- If you're submitting a Master Medical claim that will be paid to the subscriber, the filing limit will be two years. Claims for dates of service prior to a contract migrating to the Michigan Operating System are pay-subscriber claims; after migration to MOS, the provider is paid and regular filing limits apply.

For more information, contact your provider consultant.

Correct claims with Provider Claims Correction tool

Please remember to use the online Provider Claims Correction application to make corrections to claims.

The PCC tool allows you to correct claims with missing or invalid CPT or HCPCS codes, invalid revenue and procedure code combinations, or for other reasons.

Once a claim goes to the PCC application, you have 20 days to correct the claim. If you don't correct the claim in time, it will be rejected and you'll have to resubmit a corrected claim.

If you need additional information on how to correct claims by using the tool, please contact your provider consultant.

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	
A9699	**Basic Benefit and Medical Policy** Xofigo® treatment is considered established when the FDA-approved indications are met. The FDA-approved Xofigo (radium Ra 223 dichloride) for symptomatic late-state (metastatic) castration-resistant prostate cancer that has reached bones but not other organs, i.e. with no known visceral metastatic disease. This policy is effective May 15, 2013. Xofigo should be reported with not-otherwise-classified code A9699 until a permanent code is established. The recommended dose and schedule for Xofigo is 50 kBq/kg (1.35 microcuries/kg) administered by slow intravenous injection over one minute every four weeks for six doses.
UPDATES TO PAYABLE PROCEDURES	
52287* **May be billed with appropriate botulinum toxin procedure code J0585, J0586, J0587 or J0588	**Basic Benefit and Medical Policy** The safety and effectiveness of FDA-approved formulations of botulinum toxin, e.g., Botox® (onabotulinumtoxinA), Myobloc® (rimabotulinumtoxinB), Dysport™ (abobotulinumtoxinA) and Xeomin® (incobotulinumtoxinA) have been established. They may be considered useful therapeutic options for patients who meet the appropriate selection criteria, which have been updated, effective July 1, 2013. **Continued on next page**

BENEFIT POLICY continued on Page 10

BENEFIT POLICY continued from Page 9

UPDATES TO PAYABLE PROCEDURES

52287* **May be billed with appropriate botulinum toxin procedure code J0585, J0586, J0587 or J0588 ***Continued***	**Payment Policy** Service subject to preauthorization where indicated. **Inclusionary Guidelines** **Note:** The approved indications for Botulinum toxin type A and Botulinum toxin type B differ. Indications for the two botulinum toxin products have been combined in this policy. It is the responsibility of providers, however, to use each drug in accordance with approved indications unless there are valid and documented reasons stating why the unapproved or unaccepted form is used. While this policy contains a single list of covered indications, this is not meant to imply that the two botulinum toxin products (types A and B) or different brands (e.g., Xeomin vs. Dysport) are interchangeable. The use of botulinum toxin may be considered established for the following conditions. **Note:** ** indicates an FDA-approved indication for at least one of the agents. • Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to child birth injury, or traumatic injury). For this use, cervical dystonia must be associated with sustained head tilt or abnormal posturing with limited range of motion in the neck **and** a history of recurrent involuntary contraction of one or more of the muscles of the neck, e.g., sternocleidomastoid, splenius, trapezius or posterior cervical muscles** (See additional details in Policy Guidelines section.) • Strabismus*** • Blepharospasm or facial nerve (VII) disorders (including hemifacial spasm)*** • Primary focal hyperhidrosis (palmar or axillary only) in patients who meet any of the following conditions: – Acrocyanosis of the hands – History of recurrent skin maceration with bacterial or fungal infections – History of recurrent secondary infections – History of persistent eczematous dermatitis in spite of medical treatments with topical dermatological or systemic anticholinergic agents. • Upper limb spasticity*** • Dystonia or spasticity resulting in functional impairment (interference with joint function, mobility, communication, nutritional intake) or pain in patients with any of the following: **Continued on next page**

BENEFIT POLICY continued on Page 11

BENEFIT POLICY continued from Page 10

UPDATES TO PAYABLE PROCEDURES

52287*

**May be billed with appropriate botulinum toxin procedure code J0585, J0586, J0587 or J0588

Continued

- Focal dystonias:
  - Focal upper limb dystonia (e.g., organic writer's cramp)
  - Oromandibular dystonia (orofacial dyskinesia, Meige syndrome)
  - Laryngeal dystonia (adductor spasmodic dysphonia)
  - Idiopathic (primary or genetic) torsion dystonia
  - Symptomatic (acquired) torsion dystonia
- Spastic conditions (including, but not limited to):
  - Cerebral palsy
  - Spasticity related to stroke
  - Acquired spinal cord or brain injury
  - Hereditary spastic paraparesis
  - Spastic hemiplegia
  - Neuromyelitis optica
  - Multiple sclerosis or Schilder's disease

- Esophageal achalasia in patients who have not responded to dilation therapy or who are considered poor surgical candidates
- Sialorrhea (drooling) associated with Parkinson's disease
- Chronic anal fissure
- Incontinence due to detrusor overreactivity (urge incontinence), either idiopathic or due to neurogenic causes (e.g., spinal cord injury, multiple sclerosis), that is inadequately controlled with anticholinergics***
- Overactive bladder that is nonresponsive to anticholinergics or for patients who cannot tolerate anticholinergics
- Prevention (treatment) of chronic migraine headache in the following situations.*** On Oct. 16, 2010, the U.S. Food and Drug Administration approved onabotulinumtoxinA for headache prophylaxis in patients with adult chronic migraine who suffer headaches on 15 or more days per month, each lasting more than four hours.
  - **Initial six-month trial:** Adult patients who meet established diagnostic criteria for chronic migraine headache. Chronic migraine is defined as migraine attacks that meet the above criteria and occur on at least 15 days per month for at

Continued on next page

BENEFIT POLICY continued on Page 12

BENEFIT POLICY continued from Page 11

UPDATES TO PAYABLE PROCEDURES

52287*

**May be billed with appropriate botulinum toxin procedure code J0585, J0586, J0587 or J0588

Continued

least three months, provided there is no medication overuse, and have symptoms that persist despite trials of **at least two** agents used to prevent migraines or reduce migraine frequency representing different classes of medications. (Note: Patients who have contraindications to preventive medications are not required to undergo a trial of these agents). Agents used for prevention of migraines or reduction in their frequency include:

- Cardiovascular drugs (beta-blockers such as Inderal®)
- Antidepressants (tricyclics such as Pamelor®, Vivactil®, Elavil®)
  - Tricyclics (e.g., Pamelor®, Vivactil®)
  - Selective serotonin reuptake inhibitors norepinephrine reuptake inhibitors (e.g., Effexor®)
- Anti-seizure drugs (e.g., Depakote®, Topamax®, Neurontin®)
- Cyproheptadine (an antihistamine)

– Continuing treatment beyond **6 months** requires documentation that:

- Migraine headache frequency has been reduced by at least seven days per month from the time of initial presentation for migraine treatment.
- Migraine headache duration has been reduced by at least 100 hours per month from the initial presentation for migraine treatment.

Exclusionary Guidelines
With the exception of cosmetic indications, the use of botulinum toxin is considered experimental for all other indications not specifically mentioned above, including, but not limited to

- Benign prostatic hyperplasia
- Bruxism
- Chronic low back pain (including sciatica due to piriformis syndrome)
- Chronic motor tic disorder (ICD-9 307.22), and tics associated with Tourette syndrome (motor tics) (ICD-9 307.23)
- Chronic spinal pain (any location)
- Detrusor sphincteric dyssynergia (after spinal cord injury)

Continued on next page

BENEFIT POLICY continued on Page 13

BENEFIT POLICY continued from Page 12

UPDATES TO PAYABLE PROCEDURES	
52287* **May be billed with appropriate botulinum toxin procedure code J0585, J0586, J0587 or J0588 ***Continued***	• Esophageal stricture secondary to radiation therapy • Gastroparesis • Headaches, except as noted above for prevention (treatment) of chronic migraine headache • Hirschsprung's disease • Interstitial cystitis • Joint pain • Lateral epicondylitis • Mechanical neck disorders • Myofascial pain syndrome • Neuropathic pain after neck dissection • Pain after hemorrhoidectomy or lumpectomy • Sialorrhea (drooling) except that associated with Parkinson disease • Tinnitus • Temporomandibular joint disorders or myofascial or facial pain due to TMJ disorders • Tremors such as benign essential tremor (upper extremity) The use of botulinum toxin may be considered not medically necessary (cosmetic) as a treatment of wrinkles or other cosmetic indications. **Group Variations** Criteria for Federal Employee Program® members differ. Please check member benefits and eligibility on web-DENIS.
61885, 61886, 64553, 64568-64570, 95970, 95974, 95975	**Basic Benefit and Medical Policy** The safety and effectiveness of vagus nerve stimulation for the treatment of seizures has been established. It may be considered a useful therapeutic or diagnostic option when indicated. Vagus nerve stimulation has not been proven effective for the treatment of depression, it is therefore considered experimental. Inclusionary and exclusionary criteria were updated effective July 1, 2012. **Inclusionary Guidelines** • Partial-onset seizures that are refractory to conventional and newer anticonvulsant drugs • A history of at least four to six identifiable partial onset seizures each month **Continued on next page**

BENEFIT POLICY continued on Page 14

BENEFIT POLICY continued from Page 13

UPDATES TO PAYABLE PROCEDURES	
61885, 61886, 64553, 64568-64570, 95970, 95974, 95975 ***Continued***	• A diagnosis of intractable epilepsy for at least two years • Patients with epilepsy who experience breakthrough seizures or suffer from debilitating adverse effects of antiepileptic drugs • Patients with partial-onset seizures who are ineligible for epilepsy surgery or who have a history of previous epilepsy surgery which was unsuccessful in controlling the seizures • Patients with mental retardation or psychosis may be candidates for VNS if it is possible to measure the benefit to the recipient in spite of their comorbid condition **Exclusionary Guidelines** • Other types of epilepsy in patients with seizures other than partial-onset seizures • Patients with partial-onset seizures who are candidates for epilepsy surgery • A progressive seizure disorder • Treatment of depression • Other disorders not listed in the inclusions, including but not limited to: – Heart failure – Fibromyalgia – Depression – Essential tremor – Obesity – Headaches
96000-96004	**Basic Benefit and Medical Policy** The safety and effectiveness of comprehensive gait analysis have been established. It may be considered a useful diagnostic option in specified situations. The exclusions have been updated, effective Sept. 1, 2013. **Inclusionary Guidelines** • As an aid in surgical planning in patients with gait disorders associated with cerebral palsy **Exclusionary Guidelines** • Surgical planning for conditions other than gait disorders associated with cerebral palsy • Postoperative evaluation of surgical outcomes and rehabilitation planning or evaluation for all conditions • Gait analysis that is not comprehensive
J0897	**Basic Medical and Medical Policy** Diagnosis code 733.09 is now payable for procedure code J0897.

BENEFIT POLICY continued on Page 15

BENEFIT POLICY continued from Page 14

UPDATES TO PAYABLE PROCEDURES	
J7303	**Payment Policy** Effective Jan. 1, 2012, NuvaRing is payable every 28 days.
POLICY CLARIFICATIONS	
19296-19298, 77261-77263, 77280, 77285, 77290, 77295, 77326-77328, 77776-77778, 77785-77787, 0182T	**Basic Medical and Medical Policy** The criteria for the accelerated breast irradiation after breast-conserving surgery for early stage breast cancer and breast brachytherapy as boost with whole-breast irradiation policy has been updated, effective Sept. 1, 2013. **Inclusionary Guidelines** Following breast-conserving surgery for early stage breast cancer: • Accelerated whole breast irradiation for patients who meet the following conditions: – Invasive carcinoma of the breast. Exclude disease involving the margins of excision; tumors greater than 5 cm in diameter; breast width greater than 25 cm at posterior border of medial and lateral tangential beams. – Negative lymph nodes – Technically clear surgical margins • Interstitial or balloon brachytherapy may be considered established for patients undergoing initial treatment for Stage I or II breast cancer when used as local boost irradiation in patients who are also treated with breast-conserving surgery and whole-breast external-beam radiotherapy. **Exclusionary Guidelines** • Accelerated whole breast irradiation for patients not meeting the above inclusions • Accelerated partial breast irradiation, including interstitial APBI, balloon APBI, external beam APBI and intra-operative APBI • Interstitial or balloon brachytherapy in all other situations not specified under the inclusions • Local boost irradiation when combined with whole-breast radiotherapy but without surgical excision. There is a lack of published data to validate the efficacy of brachytherapy without surgical excision of the tumor.
33975-33980, 33990-33993, 0051T-0053T	**Basic Benefit and Medical Policy** The safety and effectiveness of **implantable** ventricular assist devices and total artificial hearts have been established. They are useful therapeutic options for patients meeting specified selection criteria. **Continued on next page**

BENEFIT POLICY continued on Page 16

BENEFIT POLICY continued from Page 15

POLICY CLARIFICATIONS	
33975-33980, 33990-33993, 0051T-0053T ***Continued***	The safety and effectiveness of the use of a **percutaneous** ventricular assist device (pVAD) have been established for a subset of patients with cardiogenic shock. It can be useful therapeutic intervention for patients who are being treated for cardiogenic shock and are not responding adequately to the use of medications and intra-aortic balloon pump therapy. All other uses for pVADs are considered experimental. The evidence on the use of pVADs does not support the conclusion that these devices improve health outcomes for any other situations. Inclusionary and exclusionary guidelines have been updated, effective Sept. 1, 2013. Ventricular assist devices must have FDA approval or clearance. **Inclusionary Guidelines** **For a post-cardiotomy or bridge to recovery setting** • For patients in the post-cardiotomy setting who are unable to be weaned off cardiopulmonary bypass **For use as a bridge to transplantation** • When used as a bridge to heart transplantation for adults or children 16 or younger who are undergoing evaluation to determine candidacy for heart transplantation and not expected to survive until a donor heart can be obtained • For children 16 or younger who are undergoing evaluation to determine candidacy for heart transplantation and not expected to survive until a donor heart can be obtained. **For this pediatric population, the FDA clearance also includes humanitarian device exemptions** **For use as destination therapy** • For patients with end-stage heart failure who are **ineligible** for human heart transplant and who meet one of the following "REMATCH Study" criteria: – New York Heart Association Class IV heart failure for more than 60 days – NYHA Class III/IV heart failure for 28 days, received with more than 14 days' support with intra-aortic balloon pump or dependent on IV inotropic agents, with two failed weaning attempts **Continued on next page**

BENEFIT POLICY continued on Page 17

BENEFIT POLICY continued from Page 16

POLICY CLARIFICATIONS	
33975-33980, 33990-33993, 0051T-0053T ***Continued***	In addition, patients must **not** be candidates for human heart transplant for one or more of the following reasons: – Older than 65 – Insulin-dependent diabetes mellitus with end-organ damage – Chronic renal failure (serum creatinine greater than 2.5 mg/dL for more than 90 days) – Presence of other clinically significant condition **Exclusionary Guidelines** • Patients not meeting the above patient selection guidelines • The use of non-FDA approved or cleared ventricular assist devices. For patients younger than 16, HDE approval is acceptable. **I. Percutaneous VADs** **Inclusionary Guidelines** When used as a **bridge to recovery** in patients with cardiogenic shock who are not responding to medication and concurrent intra-aortic balloon pump therapy. **Exclusionary Guidelines** • When used as an **alternative** to IABP in patients with cardiogenic shock • When used as ancillary support in high-risk patients undergoing invasive cardiovascular procedures **II. Total artificial hearts (must have FDA approval or clearance)** **Bridge to Transplantation only** **Inclusionary Guidelines** • When used as a bridge to heart transplantation for patients with biventricular failure who have no other reasonable medical or surgical treatment options who are ineligible for other univentricular or biventricular support devices • For patients who are undergoing evaluation to determine candidacy for heart transplantation and not expected to survive until a donor heart can be obtained **Exclusionary Guidelines** • Patients not meeting the above patient selection guidelines • The use of non-FDA approved total artificial hearts • The use of total artificial hearts as **destination** therapy

BENEFIT POLICY continued on Page 18

BENEFIT POLICY continued from Page 17

POLICY CLARIFICATIONS	
48550-48552, 48554, S2065 ***Continued***	**Basic Benefit and Medical Policy** The criteria for the Pancreas Transplant policy have been updated, effective Sept. 1, 2013. **Inclusionary and Exclusionary Guidelines** The following pancreas transplants are considered to be established procedures: • A combined pancreas-kidney transplant (SPK) for insulin-dependent diabetic patients with uremia • Pancreas transplant after a prior kidney transplant (PAK) for patients with insulin dependent diabetes • Pancreas transplant alone may be for patients with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness and labile insulin dependent diabetes that persists in spite of optimal medical management. • Pancreas retransplant after a failed primary pancreas transplant **Contraindications** Absolute and relative contraindications represent situations where proceeding with transplant may not be advisable in the context of limited organ or tissue availability. Contraindications may evolve over time as transplant experience grows in the medical community. Clinical documentation supplied to the health plan must demonstrate that attending staff at the transplant center have considered all contraindications as part of their overall evaluation of potential organ transplant recipients and have decided to proceed. **Relative contraindications** The selection process for approved tissue transplants is designed to obtain the best result for each patient. Therefore, relative contraindications to HSCT may include, but are not limited to: • Poor cardiac function: Ejection fraction should be greater than 45 percent with no overt symptoms of congestive heart failure. • Poor pulmonary function: Pulmonary function tests must be greater than or equal to 50 percent of predicted value. • Poor renal function: Renal creatinine clearance should be greater than 40 ml/min or creatinine must be less than or equal to 2mg/dl (unless an SPK is being done). • Poor liver function: There should be no history of severe chronic liver disease. • Presence of HIV or an active form of hepatitis B, hepatitis C or human T-cell lymphotropic virus (HTLV-1). **Continued on next page**

BENEFIT POLICY continued on Page 19

BENEFIT POLICY continued from Page 18

POLICY CLARIFICATIONS	
48550-48552, 48554, S2065 ***Continued***	**Absolute contraindications** Note: Potential contraindications are subject to the judgment of the transplant center: • Known current malignancy, including metastatic cancer • Recent malignancy with high risk of recurrence • Untreated systemic infection making immunosuppression unsafe, including chronic infection • Other irreversible end-stage disease not attributed to kidney disease • History of cancer with a moderate risk of recurrence • Systemic disease that could be exacerbated by immunosuppression • Psychosocial conditions or chemical dependency affecting ability to adhere to therapy **Pancreas Specific Guidelines** Candidates for pancreas transplant alone should additionally meet one of the following severity of illness criteria: • Documentation of severe hypoglycemia unawareness as evidenced by chart notes or emergency room visits • Documentation of potentially life-threatening labile diabetes as evidenced by chart notes or hospitalization for diabetic ketoacidosis • In addition, the vast majority of pancreas transplant patients will have Type 1 diabetes mellitus. Those transplant candidates with Type 2 diabetes mellitus, in addition to being insulin-dependent, should also not be obese (body mass index should be 32 or less). According to International Registry data, in 2010, 7 percent of pancreas transplant recipients had Type 2 diabetes. **Multiple Transplants** Although there are no standard guidelines regarding multiple pancreas transplants, the following information may aid in case review: • If there is early graft loss resulting from technical factors (e.g., venous thrombosis), a retransplant may generally be performed without substantial additional risk. • Long-term graft losses may result from chronic rejection, which is associated with increased risk of infection following long-term immunosuppression, and sensitization, which increases the difficulty of finding a negative cross-match. Some transplant centers may wait to allow reconstitution of the immune system before initiating retransplant with an augmented immunosuppression protocol.

BENEFIT POLICY continued on Page 20

BENEFIT POLICY continued from Page 19

POLICY CLARIFICATIONS	
53860, 53899	**Basic Benefit and Medical Policy** Transvaginal radiofrequency bladder neck suspension as a treatment of urinary stress incontinence is experimental. It has not been scientifically demonstrated to be as safe and effective as conventional treatment. Transurethral radiofrequency tissue remodeling as a treatment of urinary stress incontinence is experimental. It has not been scientifically demonstrated to be as safe and effective as conventional treatment. This policy has been updated, effective Sept. 1, 2013.
91110, 91111, 91299	**Basic Benefit and Medical Policy** The criteria for the Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus and Colon policy have been updated, effective Sept. 1, 2013. **Inclusionary Guidelines** • Initial diagnosis in patients with suspected Crohn's disease without evidence of disease on conventional diagnostic tests such as small-bowel follow-through and upper and lower endoscopy • Obscure gastrointestinal bleeding suspected of being of small bowel origin, as evidenced by prior inconclusive upper and lower gastrointestinal endoscopic studies • For surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome **Exclusionary Guidelines** • Use of wireless capsule for routine colorectal cancer screening, confirmation of lesions or pathology normally within the reach of upper or lower endoscopes • Evaluation for the extent of involvement or management of known Crohn's disease • Known or suspected gastrointestinal obstruction, strictures or fistulas • Evaluation of the esophagus, in patients with gastroesophageal reflux or other esophageal pathologies • Evaluation of other gastrointestinal diseases not presenting with GI bleeding including, but not limited to, celiac sprue, irritable bowel syndrome or small bowel neoplasm • Evaluation of the colon, including but not limited to, detection of colonic polyps or colon cancer • The patency capsule, when used to evaluate patency of the gastrointestinal tract before wireless capsule endoscopy

BENEFIT POLICY continued on Page 21

BENEFIT POLICY continued from Page 20

POLICY CLARIFICATIONS	
99183	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines have been updated for the Hyperbaric Oxygen Therapy – Systemic policy, effective Sept. 1, 2013. **Inclusionary Guidelines** • Removed inclusion for acute osteomyelitis refractory to standard medical management **Exclusionary Guidelines** • Added exclusion for cosmetic use.
G0237, G0239, G0424, S9473	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines have been updated for the Pulmonary Rehabilitation policy. This policy is effective Sept. 1, 2013. **Inclusionary Guidelines** Pulmonary rehabilitation may be appropriate: • Following lung transplant • For patients with disabling respiratory diseases who remain symptomatic despite optimal medical management as evidenced by all of the following: o Be physically able, motivated and willing to participate in a pulmonary rehabilitation program o Have documentation of smoking cessation or be enrolled in a smoking cessation program o Diagnosis of a chronic but stable, respiratory system impairment that is under medical management o Pulmonary function tests revealing forced vital capacity, forced expiratory volume in one second (FEV1), or diffusing capacity of the lungs for carbon monoxide (DLCO) (uncorrected for volume) less than 65 percent of predicted normal within one year prior to initiating pulmonary rehabilitation o Exhibit disabling symptoms that significantly impair the patient's level of functioning o Expectation of measurable improvement in a reasonable and predictable time frame The program must have active medical supervision that includes, at a minimum, a registered nurse providing direct supervision and a physician available on-site. The outpatient program generally includes team assessment, patient training, psychosocial intervention, supervised exercise and follow-up. Participation in pulmonary rehabilitation generally occurs for a period of four to six hours per week for eight to 12 weeks. **Continued on next page**

BENEFIT POLICY continued on Page 22

BENEFIT POLICY continued from Page 21

POLICY CLARIFICATIONS	
G0237, G0239, G0424, S9473 ***Continued***	Candidates for pulmonary rehabilitation should be medically stable and not limited by another serious or unstable medical condition. Contraindications to pulmonary rehabilitation may include: • Ischemic cardiac disease • Acute cor pulmonale • Severe pulmonary hypertension • Significant hepatic dysfunction • Metastatic cancer • Renal failure • Severe cognitive deficit • Psychiatric disease that interferes with memory and compliance • Substance abuse • Disabling stroke **Exclusionary Guidelines** • Multiple courses of pulmonary rehabilitation, either as maintenance therapy in patients who initially respond or in patients who fail to respond or whose response to an initial rehabilitation program has diminished over time. • Home-based pulmonary rehabilitation programs
EXPERIMENTAL PROCEDURES	
0281T	**Basic Benefit and Medical Policy** The use of percutaneous left-atrial appendage closure devices for the prevention of stroke in atrial fibrillation is considered experimental. This policy is effective Sept. 1, 2013.
0331T, 0332T, A9582	**Basic Benefit and Medical Policy** Myocardial sympathetic innervation imaging with meta-iodobenzylguanidine and single-photon emission computed tomography is experimental. While this procedure may be safe, its effectiveness in this clinical indication has not been scientifically determined. This policy is effective Sept. 1, 2013.
0312T-0317T	**Basic Benefit and Medical Policy** Vagal nerve blocking for the treatment of morbid obesity is experimental, effective Sept. 1, 2013. There is insufficient documentation in medical literature to indicate that the use of this device results in improved patient clinical outcomes.

BENEFIT POLICY continued on Page 23

BENEFIT POLICY continued from Page 22

GROUP BENEFIT CHANGES	
Michigan Catholic Conference – Detroit	Effective Sept. 1, 2013, Medicare-eligible retirees of the Michigan Catholic Conference – Detroit, 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 60272 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**.
Shiawassee County Road Commission	Effective Sept. 1, 2013, Medicare-eligible retirees of the Shiawassee County Road Commission, will have Blue Cross Blue Shield of Michigan's Medicare Advantage PPO plan, Medicare Plus Blue Group PPO℠, for their medical, surgical and prescription drug benefits. The group number is 60266 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**.

Healthcare Common Procedure Coding System codes updated for revenue code chart

Blue Cross Blue Shield of Michigan has made some changes to a table listing revenue codes and a description of the service categories they represent.

We're providing the updated chart below for your reference. The revenue codes and HCPCS requirements listed below are effective Oct. 1, 2013.

The original table appeared in the article titled, "Hospital outpatient reimbursement, HCPCS payment rules, revenue code information summarized," in the January 2013 *Record*.

Changes to the table include:

- Revenue code 0255 was deleted from the "drug and pharmacy" (IVT-chemo) category, and revenue code 0750 was added to the "other" category.
- Revenue codes marked with a single asterisk won't always have CPT or HCPCS codes that can be reported with them. For example, there are no CPT or HCPCS codes available for certain medical supplies. Just use the appropriate revenue code for the medical supplies dispensed.

Description	Revenue codes that require HCPCS codes
Surgery (including maternity)	0360, 0361, 0369, 0490, 0499, 0700, 0750, 0769, 0790 Codes that require a surgical HCPCS code if surgery is performed in this room: 0450, 0451, 0452, 0456, 0510, 0511, 0512, 0513, 0514, 0515, 0516, 0519, 0761
Laboratory – clinical or anatomical	0300, 0301, 0302, 0303, 0304, 0305, 0306, 0307, 0309, 0310, 0311, 0312, 0314, 0319, 0923, 0924, 0925

HOPS continued on Page 24

HOPS continued from Page 24

Description	Revenue codes that require HCPCS codes
Other	0270*, 0271*, 0272*, 0279*, 0280, 0289, 0370, 0379, 0380, 0381, 0382, 0383, 0384, 0385, 0386, 0387, 0389, 0390, 0391, 0392, 0399, 0410, 0412, 0413, 0419, 0450, 0451, 0452, 0456, 0459, 0460, 0469, 0470, 0471, 0472, 0479, 0480, 0481, 0482, 0483, 0489, 0500, 0509, 0510, 0511, 0512, 0514, 0515, 0516, 0517, 0519, 0530, 0531, 0539, 0540, 0545, 0621, 0622, 0623, 0730**, 0731, 0732, 0739, 0740, 0780, 0920, 0921, 0922, 0929, 0940, 0942, 0943, 0949, 0951, 0952, 2101, 2105, 2106
Durable medical equipment/prosthetic & orthotic devices	0274, 0291, 0292, 0293, 0946, 0947
Drug administration	0260, 0331, 0332, 0335, 0771
Drug and pharmacy	0250*, 0251, 0252, 0253, 0254, 0256, 0257, 0258, 0259, 0262, 0631, 0632, 0633, 0634, 0635, 0636, 0637
Radiopharmaceutical	0255, 0343, 0349
Radiology	0255, 0320, 0321, 0322, 0323, 0324, 0329, 0330, 0333, 0339, 0340, 0341, 0342, 0343, 0344, 0349, 0350, 0351, 0352, 0359, 0400, 0401, 0402, 0403, 0404, 0409, 0610, 0611, 0612, 0614, 0615, 0616, 0618, 0619, 0860, 0861
Emergency room and trauma	0450, 0451, 0452, 0459, 0681, 0682, 0683, 0684, 0689
Surgery (maternity)	Refer to “Surgery”
Treatment room	0761
Observation room	0762
Physical therapy, occupational therapy, speech and language pathology evaluation	0424, 0434, 0444
Physical therapy, occupational therapy, speech and language pathology visit	0421, 0431, 0441

****** Ambulatory surgery facilities must report the applicable EKG CPT or HCPCS code when reporting revenue code 0730. Other applicable revenue codes and CPT or HCPCS code information for laboratory, radiology and surgery services are included above.

Members eligible for prehospice counseling visits

Please remember that Blue Cross Blue Shield of Michigan members who are not on Medicare are eligible for up to 28 prehospice counseling visits prior to making a decision on whether to enter hospice care.

Hospice staff will help members and families understand the care options and assist the member in getting early pain management and other services as needed. The member may continue to receive ongoing treatment while receiving hospice counseling visits.

Visits are not charged against the patient’s hospice day or dollar benefit maximums. The hospice bills these services under revenue code 0650. Only one service a day is billable.

Should the member elect hospice care, five levels of care are available: routine home care, continuous home care, inpatient respite care, general inpatient care and nursing home care with hospice support. (Not all groups cover the last level, and not all hospices provide it.)

HOSPICE continued on Page 25

HOSPICE continued from Page 24

The following services are covered when billed by the hospice under the appropriate level of care:

- Nursing care services provided by or under the supervision of a registered nurse
- Medical-social services provided by a Michigan licensed social worker with a master's degree or licensed social worker with a bachelor's degree when supervised by a social worker with a master's degree
- Counseling services for the member and caregivers when care is in the member's home
- Direct care physician services provided by a physician employed or contracted by the hospice
- Durable medical equipment approved by BCBSM and provided by the hospice for use in the member's home to relieve or reduce symptoms of the member's terminal illness
- Medical appliances and supplies, including drugs and biological items, provided to relieve or reduce the symptoms of the member's terminal illness
- Home health aide and homemaker services provided by qualified aides under the general supervision of a registered nurse. These would include services such as:
  - Assisting the member in getting in and out of bed
  - Bathing the member
  - Caring for the member's hair and teeth
  - Laundering
  - Preparing meals and feeding the member
- Physical, occupational and speech therapy to control symptoms or to enable the member to maintain daily living activities and basic functional skill
- Bereavement counseling for the family after the member's death

For more information, refer to the online *Hospice Provider* manual for covered services and requirements.

InterQual® webinar training classes in September

Join us online for a free series of InterQual criteria training classes this September. We'll provide training and answer your questions about all five InterQual criteria sets: acute care, skilled nursing facilities, rehabilitation care, long-term acute care and home health care.

To sign up for the webinars, please e-mail **jholzhausen@bcbsm.com** with "InterQual" and the names of the webinars you wish to attend in the subject line. Include your name, title and organization name. Space is limited; register at least one week prior to the webinar date. Once registered, we'll e-mail you a registration confirmation with additional details.

If there are multiple people from one facility who wish to attend, it is suggested they call in from a single computer and listen in on the computer's speakers.

Attendees may also listen via phone only. We'll provide the phone number upon registration.

Dates of webinars

Acute Care (Adult and Pediatric)	Sept. 17, 9 a.m. (three to four hours)
Skilled Nursing Facilities	Sept. 18, 10 a.m. (one hour)
Rehabilitation Care	Sept. 18, 11 a.m. (one hour)
Long-Term Acute Care	Sept. 19, noon (one hour)
Home Health Care	Sept. 19, 1 p.m. (one hour)

Laboratory fee increases for select physician office lab tests

Blue Cross Blue Shield of Michigan pays health care providers an additional $5 per billing for LDL-C and HbA1c screening lab services, as of July 15, 2013. This is for services performed in a physician office setting for members with PPO, Traditional and Medicare Advantage PPO plans when billed with the correct CPT® Category II codes.

MA LAB FEE continued on Page 26

MA LAB FEE continued from Page 25

This increase impacts LDL-C screening procedure codes *83721 and *80061 (*80061 effective Aug. 7, 2013, for MA PPO) and HbA1c screening procedure code *83036. See the table at right for the associated CPT Category II codes. CPT Category II codes must be reported on the same claim as the service to receive the additional reimbursement.

These CPT Category II codes represent results of the tests in the form of a range of values. For example, if a screening LDL cholesterol is performed in the office and the result is in the range of 100-129 mg/dL, this is reported by using CPT code *80061 (representing the test performed) and CPT II code *3049F (indicating that the result is in the 100-129 mg/dL range).

Using these codes will decrease the number of charts we will need to request to determine our HEDIS®** performance.

CPT Category II codes describe components usually included in evaluation and management of clinical services, such as test results. When used, these codes may decrease the number of charts requested for review for HEDIS purposes.

The following table lists the select lab tests with physician office-billable CPT Category I codes and the associated CPT Category II codes.

Select lab services with BCBSM-required use of CPT Category II codes:

Laboratory test	CPT code*	CPT II code*
LDL-C screening	83721 80061 (80061 effective on 8/7/2013 for MA PPO)	3048F 3049F 3050F
HbA1c screening	83036	3044F 3045F 3046F

On or after Oct. 15, 2013, BCBSM will no longer reimburse physician offices for laboratory services *83721, *80061 (date excludes MA PPO) and *83036 without submission of the associated CPT Category II codes. MA PPO will no longer reimburse *80061 without the submission of associated CPT Category II codes **on or after Nov. 7, 2013.** These details can be found in the July 15 and Aug. 7 web-DENIS broadcast messages.

Look for future BCBSM communications regarding these dates.

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

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

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Audit identifies inappropriately paid claims for autologous PRP injections

Inappropriately paid claims for autologous platelet rich plasma preparations and injections have been identified through recent utilization review trend analysis and audits.

BCBSM medical policy titled “Recombinant and Autologous Platelet-Derived Growth Factors as a Treatment of Wound Healing and Other Conditions” states that the use of autologous platelet-derived growth factors or autologous platelet concentrate and/or gel has not been established and is, therefore, considered experimental. You can find the policy by looking up procedure code *0232T in Benefit Explainer, available through web-DENIS.

Upon review, recovery will be requested for paid claims associated with the retrieval and administration of autologous PRP injections, unless the procedure is specifically listed as a member contract benefit. As always, continue to use the Benefit Explainer tool to check member benefits.

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

HCPCS modifier added

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

The new code is listed at right.

Code	Change	Coverage Comments	Effective Date
AO	Added	Informational only	Oct. 1, 2013

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

BCBSM has launched an initiative to process all medical drug claims at the national drug code level. Home infusion therapy providers, ambulatory infusion centers and hemophilia care providers' claims have been processing at the national drug level for some time.

BCBSM will begin processing Walgreens' Specialty Pharmacy and limited distribution drug specialty pharmacy network providers' claims at the national drug code level Oct. 25, 2013.

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

We've already requested that you include NDCs and the appropriate quantities on claims for informational purposes, the way you have in the past for not-otherwise-classified procedure codes. We continue to process individual provider professional medical drug claims, based on the procedure code and quantity, to give health care providers time to adjust their billing processes.

We plan to begin processing individual provider professional medical drug claims at the NDC level Feb. 1, 2014. This applies to physicians, advanced practice nurses, physician assistants, immunization pharmacies and durable medical equipment providers. If the date changes, we will communicate that to you.

For these providers, we will implement NDC pricing in stages. We'll start with a select group of codes that we will publish on web-DENIS. After a few months of adjusting to this process, we will expand this effort to all medical drug claims for these providers.

We will continue to communicate these changes as they arise.

Finding the NDC and unit of measure

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

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

Submitting the NDC on claims

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

- The NDC must be submitted along with the applicable Healthcare Common Procedure Coding System or Current Procedural Terminology® code.
- The NDC must follow the "5digit4digit2digit" format (11 numeric characters with no spaces or special characters). If the NDC on the package label is fewer than 11 digits, you must add leading zeroes to total 11 digits.
- The NDC must be active for the date of service.

PHARMACY continued on Page 28

PHARMACY continued from Page 27

- To submit electronic claims (ANSI 837P), report the following information:

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

- To submit paper claims, enter the NDC information in field 24 of the CMS-1500 claim. In the **shaded portion** of field 24A-24G, enter the qualifier "N4" left-justified, immediately followed by the national drug code. Next, enter the appropriate qualifier for the correct dispensing unit (GR, UN, ML or ME), followed by the quantity and the price per unit, as indicated in the example below.
- The format for billing should be:
  N4 + NDC code + 3 spaces + unit of measure + quantity
  Example: N4555103026710 ML5.5

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

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

Group prior authorization information available on web-DENIS

We've posted on web-DENIS a list of the groups that do not require prior authorization of these specialty drugs provided by a health care practitioner and covered under medical benefits.

Health care practitioners must obtain prior authorization for 13 specialty drugs before administering them to all other members. The program began Jan. 22. To see the list of drugs and other information about the prior authorization requirement, see the article titled "Additional practitioner-administered specialty drugs to require prior authorization" in the January *Record*.

To find the group prior authorization exception list online:

- Log in to web-DENIS.
- Click on *Commercial Pharmacy Prior Authorization and Step Therapy Forms*.
- Click on *Physician administered medications*.
- Click on *BCBSM Medical Drug Prior Authorization Program list of groups that have opted out*.

BCBSM recredentials DME providers

We're currently in the process of recredentialing all providers in our durable medical equipment network.

As part of this effort, we're asking each DME provider to submit the certification letter it received from the Centers for Medicare & Medicaid Services, as well as a current copy of its site accreditation. Be sure to include your BCBSM provider identification number and national provider identifier on all correspondence.

Fax all supporting documents to 1-866--587-6920 no later than Sept. 30, 2013. If you've already supplied this information to your BCBSM provider consultant on or after July 1, 2013, you don't need to submit a second copy.

If you can't locate your CMS letter, you can request a copy from the National Supplier Clearinghouse website at **palmettogba.com/nsc***. It generally takes seven to 10 business days to receive it by mail.

As explained in your contract with BCBSM, failure to submit these documents could result in termination of your contract, audit and recoveries.

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

Requirements change for URMBT members receiving organ transplants

Members whose benefits are paid for through the UAW Retiree Medical Benefits Trust must adhere to the following requirements to receive coverage for organ transplant procedures and services.

As of Jan. 1, 2012, the following requirements apply for URMBT non-Medicare members covered by Blue Cross Blue Shield of Michigan:

- Receive prior authorization from the BCBSM Human Organ Transplant Program for transplant procedures by calling 1-800-242-3504.
- Enroll in and participate in the BCBSM Case Management program from the time of authorization through the duration of transplant organ services. For information on enrollment, members can call 1-800-845-5982.
- Obtain transplant services through one of the Blue Distinction Centers for Transplants®, part of the Blue Cross and Blue Shield Association's Blue Distinction Centers for Specialty Care®.

To confirm your BCBSA Blue Distinction Center for Transplant status, please call 1-800-242-3504.

Also, effective Jan. 1, 2012, URMBT members with Medicare primary coverage must:

- Be limited to Medicare-approved transplants only
- Enroll in and participate in the BCBSM Case Management program for the duration of transplant organ services

These requirements apply to all transplants except cornea, kidney and skin.

For more information about the Blue Cross and Blue Shield Association's Blue Distinction Centers for Specialty Care®, go to **bcbsa.com**.

Deadline approaches for closing diagnosis gaps

In order to earn an incentive as part of the Diagnosis Closure Incentive Program, physicians must close all the diagnosis gaps that exist for a patient through a face-to-face visit before the end of this calendar year or notify the Blues that the patient does not have the suspected diagnosis.

MA DIAGNOSIS INCENTIVE continued on Page 30

MA DIAGNOSIS INCENTIVE continued from Page 29

Through the program, Blue Cross Blue Shield of Michigan and Blue Care Network provide an incentive to primary care physicians who close diagnosis gaps for their Blues Medicare Advantage members. The diagnosis gaps are listed on Health e-Blue℠ under *Panel – Diagnosis Evaluation*.

All of the diagnosis gaps included in the 2013 incentive will be identified on Health e-Blue by the end of September.

Diagnosis gap closures must be submitted to the Blues by the following dates:

Method	Deadline
Claim submission	Received by Jan. 31, 2014
Health e-Blue	Input by Jan. 24, 2014
Electronic medical record	Received by Feb. 28, 2014
Paper Member Diagnosis Evaluation and Treatment Opportunities report submission (for BCBSM out-of-state providers and in-state BCBSM providers without access to Health e-Blue)	Faxed or postmarked by Jan. 31, 2014
Paper medical record submission	Faxed or postmarked by Jan. 31, 2014

More information about the incentive program is available in the Resources section of Health e-Blue by clicking on *2013 Diagnosis Closure Incentive Program and 2013 Diagnosis Closure Program FAQ*. Also, a fact sheet can be found on web-DENIS within *BCBSM Provider Publications and Resources*. Click on *Newsletters & Resources*, then click on *Medicare Advantage Resources*.

If you do not have access to Health e-Blue, sign up today.

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

Medicare Advantage HCC model is changing

Upcoming revisions to the Medicare Advantage Hierarchical Condition Categories model will impact members' risk scores.

The HCCs are being modified to reflect changes in ICD-9-CM codes that have occurred since the late 1990s, when the current HCCs were created. ICD-9-CM codes are the national standard coding language used to translate a patient's clinical condition into three- to five-digit codes.

The Centers for Medicare & Medicaid Services announced the revisions on April 1, 2013, and changes will affect the 2014 payment year.

Features of the new model include:

- Major changes in several areas, including chronic kidney disease, diabetes, polyneuropathy, morbid obesity and neurological and metabolic disorders
- Diseases previously included in an HCC with other related conditions will have their own HCCs. These conditions include quadriplegia, cerebral palsy, amyotrophic lateral sclerosis and other motor neuron diseases, as well as atherosclerosis of the extremities with ulceration or gangrene.
- Seventy-nine HCCs — compared with 70 in the previous model
- It removes 129 ICD-9-CM codes that were in the previous model. These codes mapped to condition categories such as kidney disease, major complications of medical care, neurological diseases and cardio-respiratory failure and shock.

MA HCC continued on Page 31

MA HCC continued from Page 30

CMS is also introducing 224 new ICD-9-CM codes related to condition categories such as morbid obesity, lung disorders, hematological disorders and spinal cord disorders and injuries.

For more information about changes to the Medicare Advantage HCC model, visit **hccublog.scanhealthplan.com/2013/04/risk-adjustment-changes-for-2014.html*** or contact your Blue Cross Blue Shield of Michigan provider consultant or Blue Care Network provider representative.

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Medicare Advantage Risk Adjustment Model adding HCC for morbid obesity

Morbid obesity has been assigned its own Hierarchical Condition Categories code as part of the changes to the Medicare Advantage Risk Adjustment Model. These changes will take effect with 2013 dates of service and the 2014 payment year.

"Morbid obesity has become such a prevalent problem in our country that the Centers for Medicare & Medicaid Services has this year elevated morbid obesity to be its own HCC in the Medicare Advantage Risk Adjustment Model," said Thomas Ruane, M.D., medical director, Federal Business Division, Blue Cross Blue Shield of Michigan.

Proper coding and documentation for morbid obesity will ensure an accurate member risk score and appropriate reimbursement. It will also help guarantee that patients receive the best and most affordable care possible.

Dr. Ruane pointed out that simply documenting the patient's weight isn't enough information for complete specificity.

When documenting morbid obesity in a patient's medical records, it's important to note his or her body mass indexand weight. If a physician documents a patient's BMI but doesn't state that the obesity is severe or morbid, then the condition can't be reported to the Centers for Medicare & Medicaid Services.

Adult BMI is a Healthcare Effectiveness Data and Information Set measure, making it an important indicator in effectively treating patients for obesity.

Documenting BMI

The degree of obesity and the BMI should be documented to indicate morbid obesity for adults 20 and older. The BMI categories, with their ICD-9-CM codes in parentheses, are:

- Normal BMI, 19 to 24
- Overweight (278.02), BMI 25 to 29.9 (V85.21 to V85.25)
- Obese (278.00), BMI 30 to 39.9 (V85.30 to V85.39)
- Morbid obesity (278.01), BMI 40 to 49.9 (V85.41 to V85.42)

Once a patient has been diagnosed as morbidly obese, a complete treatment plan should be recommended. The plan may include the following:

- Dietary consult
- Describing how the condition impacts the patient's health
- Recommendation of exercise
- Weight loss medication
- Physician and patient discussions about concerns
- Monitoring patients' weight gain or loss
- Bariatric consultation
- A diet consisting of 1,800 calories per day

For more information on the morbidly obese HCC, visit **hccublog.scanhealthplan.com/2013/04/risk-adjustment-changes-for-2014.html***.

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BCBSM adds 2 codes to Medicare Advantage PPO Physician Office Laboratory List

On Aug. 5, 2013, Blue Cross Blue Shield of Michigan Medicare Advantage added two new codes to its MA Physician Office Laboratory List: codes *83037 and *80061.

The addition of these two codes allows our providers to bill and be reimbursed for providing these two services in an office setting and lab environment.

The procedures listed on the Medicare Advantage PPO Physician Office Lab List are services that are appropriate in an office setting. If lab services are provided and are not on this list, then they're not considered payable, and members can't be balance-billed for those services.

Remember to also use the appropriate CPT II code on the claims to communicate the results of these screening tests. See article titled "Laboratory fee increases for select physician office lab tests" on Page 25.

For more details, see the Aug. 5, 2013, web-DENIS message on the MA PPO Physician Office Laboratory List. If you have any questions, contact your provider consultant.

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

Medicare Advantage enhanced benefit fee schedule to be updated in October

The Blue Cross Blue Shield of Michigan Medicare Advantage enhanced benefit fee schedule will be updated in October to show BCBSM allowed amounts for both facility and non-facility locations.

These changes will affect health care providers' payments for enhanced benefit services related to physician services performed in a facility location. The fee schedule will not include incentive amounts.

Physician payments for MA enhanced benefits will be reduced, starting Oct. 6, 2013. The enhanced benefit fee schedule on our provider website, **bcbsm.com/provider/ma**, will be updated on this date.

For more information, see the Aug. 6, 2013, web-DENIS message.

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
- And much more

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

Contact Us

CAREN (eligibility and benefits)

Professional providers	1-800-344-8525
Hospitals and facilities	1-800-249-5103
Vision and hearing providers	1-800-482-4047

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
Questions about BCBSM employees only	1-877-258-0167

If you're calling from this area code (hospitals and facilities)

248, 313, 517, 586, 734, 810, 947 or 989	1-800-228-4599 (hospitals) 1-800-437-3804 (facilities)
231, 269, 616, *989	1-800-643-2583
906	1-866-872-5837
Outside Michigan	1-800-482-0898
Questions about BCBSM employees only	1-877-258-0167

Vision and hearing providers

248, 313, 517, 586, 734, 810, 947, 989 or outside Michigan	1-800-482-5141
231, 269, 616, *989	1-800-531-2583
906	1-866-872-5837
Questions about BCBSM employees only	1-877-258-0167

*989 counties: Alcona, Alpena, Crawford, Iosco, Montcalm, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle and Roscommon

Provider Consulting Services, Manager's Office

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

Provider Contracting (facility)

1-800-777-2118

providercontracting@bcbsm.com

Provider Enrollment and Data management (professional)

1-800-822-2761

Physician Ombudsman office

1-800-816-BLUE (2583)

Other valuable contact information

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

Electronic Claims Submission

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

Corporate Communications – MC 0245

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