October 2013

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Print version of *The Record* to be discontinued Feb. 1, 2014

We'll discontinue the print version of *The Record* Feb. 1, 2014, to focus on the email version as part of our commitment to give you fast, easy access to the news and information you need.

The email version of *The Record* arrives in your inbox on the last business day of the month prior to the issue date. That means that current subscribers should have received this issue Sept. 30. That's several days before print edition subscribers receive this issue in the mail.

If you haven't yet subscribed to the electronic *Record*, it's easy to do. Simply go to **bcbsm.com/providers**:

- Click on *Newsletters* in the box at right.
- Click on the *subscribe* link at the top of the screen.
- Fill out the required information and select *The Record*.

You'll be asked to *Select a Topic* that reflects your main area of interest (for example, Professional, Facility, Pharmacy, etc.). Articles about these topics will appear first in your personalized issue of the newsletter each month.

Current and archived issues of the electronic version of *The Record* also can be easily accessed from **bcbsm.com/providers**.

- Click on *Newsletters*.
- Under *The Record*, select current issue or archive.

We hope this development will support you in your efforts to streamline your business operations and make it easier for you to do business with us.

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

Blues to discontinue paper remittance advices

By the end of 2013, Blue Cross Blue Shield of Michigan and Blue Care Network will no longer print and mail paper remittance advices, or vouchers. Watch future issues of this newsletter for the date when paper remittance advices will end.

Participating providers and facilities, as well as Michigan enrolled nonparticipating providers who are not using electronic funds transfer, are impacted. Out-of-state providers and facilities who are paid through the Medicare crossover process will continue to receive paper remittance advices.

These changes are part of the actions we are taking as a result of the federally mandated EFT-ERA Operating Rule requirements. These rules are a component of the Administrative Simplification provisions specified in the Patient Protection and Affordable Care Act. This part of health care reform is meant to reduce administrative costs associated with health care through standardization, enhancing ease of doing business between insurers and providers, and promoting the growth of online recordkeeping. Discontinuing paper remittance advices will also:

- Reduce the amount of paper you have to manage
- Introduce you to the search benefits of online remittance advices
- Eliminate problems associated with multiple mailings of checks and paper vouchers, including the incidental disclosure of protected health information by mail when addresses change and are not updated in our system.
- Allow us to all be more environmentally friendly
- Help keep health coverage affordable

How to search for remittance advices online
All Michigan health care providers and those outside of the state who have a contract with BCBSM or BCN have the ability to access online remittance advices for the Blues. To view them, providers must sign up for Provider Secured Services. Then go to **bcbsm.com/vouchers** to find the steps to access up to three years of remittance advice history with the ability to search by check number, EFT trace number, period of time or for a specific patient.

Sign up for electronic funds transfer
All professional providers should already be signed up for electronic funds transfer. If you are not, register for EFT to begin receiving electronic payments from the Blues. EFT gives you faster access to your payments and there is no cost to participate.

You can get instructions for registering by going to **bcbsm.com/providers**.

- Click on *Provider Secured Services*.
- Click on *Online payments and electronic vouchers*.

Not all BCBSM hospitals and facilities have access to EFT today, but will be able to register by the end of 2013. Watch for more information in future issues of *The Record* and *BCN Provider News*.

Where to go for help
If you need help accessing online remittance advices or signing up for Provider Secured Services or electronic funds transfer, contact your BCBSM provider consultant or BCN provider representative. For technical assistance, you can also call the BCBSM Web Support Help Desk at 1-877-258-3932 Monday through Friday from 8 a.m. to 8 p.m. Eastern time.

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.

BCBSM provides official notice of changes to appeals process

As we've been telling you, earlier this year Governor Snyder signed Public Acts 4 and 5, the acts that enabled BCBSM to begin a transition to a nonprofit mutual insurer, governed by the Michigan Insurance Code rather than Public Act 350. During the transition, we discovered that it was necessary to revise the provider appeals process. The information in this article will serve as official notification of the appeal process changes.

Background of appeals changes
Under PA 350, providers had access to the Department of Insurance and Financial Services for appeals of BCBSM decisions regarding post payment audits and post service claims. Under the Michigan Insurance Code, DIFS will no longer serve that function. Therefore, we must eliminate this step in our provider appeals process and change the language in our agreements and provider manuals to reflect this change.

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BCBSM has documented a process that replaces binding arbitration and access to DIFS with an external peer review by an independent review organization for non-policy (medical and clinical) issues. As such, providers who are dissatisfied with the internal appeals process findings regarding non-policy issues, such as medical necessity, pre-existing conditions or coding accuracy may request an appeal by an independent review organization.

All providers will continue to have access to their current internal appeal process, which includes written inquiry and informal managerial conferences.

Changes to the appeals process have been approved by the board of directors and will be effective Jan. 1, 2014.

Where to find more information about the appeals process changes
For the provider types listed below, the participation agreements have been updated to include the revised appeals process. Those agreements are located in the provider manuals on web-DENIS:

- Ambulance
- Certified registered nurse anesthetist
- End stage renal disease facility (Traditional contract)
- End stage renal disease facility (TRUST contract)
- Hearing specialist
- Hospice
- Long-term acute care hospital
- Practitioners (M.D., D.O., chiropractors, fully-licensed psychologists and podiatrists)
- Vision specialists (ophthalmologists and optometrists)
- Freestanding and hospital-based substance abuse facility
- Skilled nursing facility

For all other provider types, be sure to check your online provider manual beginning Oct. 1, 2013, to see the most up-to-date appeals process.

Note: The changes outlined above impact all health care providers except for hospitals.

If you have questions, contact your provider consultant.

Blues introduce new health reform compliant products

Blue Cross Blue Shield of Michigan and Blue Care Network are introducing a wide array of new health care products for individuals (those without health care coverage through an employer or other group) and small groups (with 50 or fewer full-time-equivalent employees). The new products are fully compliant with Patient Protection and Affordable Care Act regulations.

They are available for purchase starting Oct. 1, 2013, for coverage beginning Jan. 1, 2014 or later. The Blues' individual products will be available Oct. 1 online at **bcbsm.com**. Oct. 1 is also the day we expect the Michigan Marketplace to open.

All of the new health care products cover the Affordable Care Act-mandated essential health benefits of the State of Michigan benchmark health care plan. For more information on essential health benefits, see the article titled "A look at essential health benefits" on Page 2 of the August issue of *The Record*.

All of the new health care products cover the same services, including:

- Office visits (including mental health and substance abuse treatment)
- Inpatient hospital days (including mental health and substance abuse treatment)
- Maternity care (pre- and postnatal, delivery and newborn care)
- Preventive services with no co-sharing, as required by the ACA
- Allergy testing and therapy
- Outpatient physical and occupational therapy is covered for a combined 30 visits per year. For BCBSM PPO plans, this includes spinal manipulation when performed by a chiropractor or osteopathic physician. BCN individual and small group products have a separate 30-visit limit per year for spinal manipulation when performed by a chiropractor or osteopathic physician.
- Outpatient speech therapy up to 30 visits per year
- Durable medical equipment, prosthetics and orthotics
- Home health care visits

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- Pediatric dental benefits are offered in a separate product for eligible members through the end of the plan year in which the member turns 19. Individuals and small groups need to have pediatric dental coverage. This coverage can be purchased as a separate plan from the Blues, purchased through another carrier, or the required pediatric coverage will be packaged with the medical plan.
- Pediatric vision coverage is included in all plans (for children through the end of the plan year in which the member turns 19)
- Bariatric surgery
- Sleep studies
- Additional coverage of preventive drugs
- Pharmacy coverage with additional tiers

What differs between the new plans is:

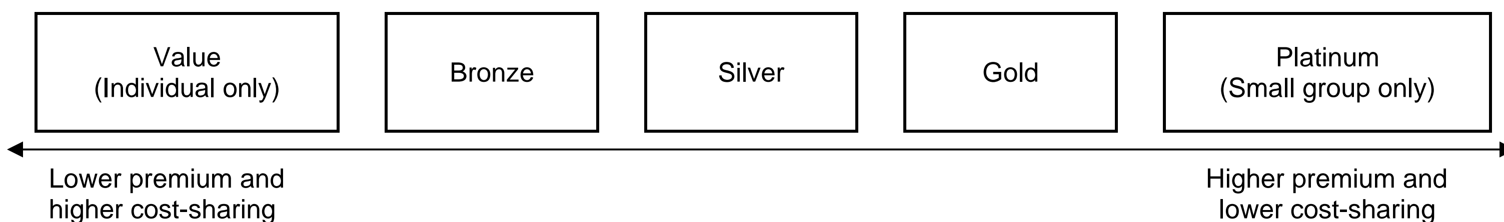
- The amount of member cost-sharing (Higher cost-sharing results in lower premiums.)
- The provider network (HMO plans have smaller networks and can offer lower premiums.)
- Managed care (HMO plans offer lower premiums than PPO plans.)

The Blues are offering 18 new individual medical products. For small groups, we are offering a total of 46 new medical products, of which eight will be available on the Marketplace's Small Business Health Options Program, also known as SHOP. Individuals and small groups can purchase benefits directly from the Blues, through health insurance agents, health plan advisors or through the Marketplace.

Government subsidies for qualified individuals and tax credits for small businesses are only available through the Marketplace. The Blues website has a calculator to help shoppers learn whether a subsidy or tax credit is available to them.

The new Blues individual and small group products span from lower premium, higher cost-sharing value plans up to higher premium, lower cost-sharing platinum options. We're offering a broad array of plans so individual or small group purchasers can choose the best fit for their needs and budgets. We want you to be aware of the plans we have available so you can help your patients if they come to you for advice.

Marketplace metal levels



Five different Blues medical plans for individuals:

- **Blue Cross® Multi-State**, offered to Michigan residents only through the Marketplace website, has BCBSM's PPO network with nationwide coverage. Member cost-sharing is lower when services are obtained within the network. These are the only Blues individual plans that provide medical, prescription, pediatric and adult dental and vision coverage all in one plan. Offered in silver and gold options.
- **Blue Cross® Premier** has BCBSM's PPO network with nationwide coverage. Member cost-sharing is lower when services are obtained within the network. Offered in four options: value, bronze, silver and gold.
- **Blue Cross® Preferred** has BCN's statewide HMO network. Care must be coordinated by a primary care physician. Offered in four options: value, bronze, silver and gold.
- **Blue Cross® Select** has BCN's PCP Focus HMO network. Care must be coordinated by a primary care physician. Offered in four options: value, bronze, silver and gold.
- **Blue Cross® Partnered** for residents of Kent, Muskegon and Oceana counties who agree to receive care within the Mercy Health network, following BCN HMO policies, with care coordinated by a Mercy Health primary care physician. Care within BCN's entire HMO network, but outside the Mercy Health network, requires

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plan authorization. More information about BCN's Mercy Health partnership is available in the Sept.-Oct. 2013 *BCN Provider News*. Offered in four options: value, bronze, silver and gold.

Blues medical plans for small groups
There are many options available for small group purchase. Most are similar to products offered by the Blues in 2013, with adjustments to meet essential health benefits and other health care reform requirements. Options include familiar plans like Community Blue PPO[SM] and Blue Care Network's standard HMO, along with consumer-directed health plans such as health reimbursement arrangement options and health savings accounts, and wellness products like BCN's Healthy *Blue* Living[SM] and a new BCBSM Healthy Blue Achieve PPO[SM].

Features applying to the new plans

Copays
The new plans have tiered copays offering lower out-of-pocket costs for office visits with a primary care physician and higher costs for specialist visits and facility care. In some cases, government subsidies can result in no copays for individual (non-group) silver plans. Cost-sharing subsidies do not apply to small group employer plans.

Coinsurance
Plans that include coinsurance have percentage cost-sharing that ranges from 10 to 60 percent. Plans that offer an out-of-network benefit include higher coinsurance costs for seeking care outside the provider network. Note that government subsidies can lower coinsurance requirements for specific members enrolled in the individual silver plans. Government subsidies do not apply to small group employer plans.

Integrated deductible for individual plans
These new individual plans have deductibles that include all medical and prescription drug expenses. This is different from most current plans, with the exception of high-deductible health plans, which have integrated deductibles today. Small group plans do not have an integrated deductible, except for the high deductible health plans.

Out-of-pocket maximum
The new plans all have an out-of-pocket maximum. The out-of-pocket maximums include all medical and prescription drug deductibles, coinsurance and copays. Once the member reaches the out-of-pocket maximum, the member pays no further cost-sharing for the remainder of the year for covered services — including no further copays for medical services or prescription medications. Cost-sharing for dental and adult vision services is not included in the out-of-pocket maximum. There is no cost-sharing for pediatric vision. Note that government subsidies can lower coinsurance requirements for specific members enrolled in the individual silver plans. Government subsidies do not apply to small group employer plans.

Two current individual plans will stay around through 2014
Members who have a current Blues individual health care plan must move to one of the new health reform compliant plans as of Jan. 1, 2014, with two exceptions. The following two Blues individual plans are open for new enrollment until Dec. 1, 2013, and members in these non-health care reform compliant plans can remain in their plans until the end of 2014:

- BCBSM's Keep Fit[SM]
- Blue Care of Michigan's Personal Plus[SM]

These two plans keep their current benefits and cost-sharing levels through the end of 2014.

Group changes happen on the group's 2014 plan renewal date
All group coverage must become health care reform compliant at the group's 2014 plan year, which is typically aligned with the renewal date. Many groups renew in January, but plan years happen throughout the year so at least some non-health care reform compliant plans will be active throughout 2014.

What does this mean to health care providers?
Make sure you always check eligibility and benefits before providing services. When checking benefits, you should also check to see if patients have reached their out-of-pocket maximums. If an out-of-pocket maximum applies, it will be noted on the Medical Benefits screen on web-DENIS. If you see an out-of-pocket maximum listed on web-DENIS, it is a health care compliant out-of-pocket maximum and includes all member cost-sharing (copays, coinsurance and deductibles for both medical and pharmacy) unless otherwise noted.

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When you see an out-of-pocket maximum listed, make sure you check the member's accumulators before charging cost-sharing for services. Here's how to do this on web-DENIS:

- Click on *Subscriber Info*.
- Click on *Deductible/Copay* and input the member's contract number.
- Select the member's line of business and click on *Enter.*
- Click on the member's name.

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Focus on health care reform: Advanced Premium Tax Credit grace period explained

As we've been telling you in our newsletters and through various informational sessions, health care reform will bring many changes to the industry and these changes will impact your daily business.

The Patient Protection and Affordable Care Act mandates a three-month grace period for Marketplace-purchased individual insurance policies that receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year.

The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA specifies that the health insurance plan may pend claims during the second and third months of the grace period.

If this happens, health care providers will notice this special message, during months two and three of the grace period, when they check eligibility on web-DENIS or on CAREN:

> Contract is active but not current. Claims will be held until the member makes the appropriate payment to bring the contract to a current status, or until payment is no longer accepted and the coverage is terminated. There is no guarantee of payment for services rendered during this time period.

The Blues' policy for the grace period is as follows:

- For claims with dates of service during the first month, Blue Cross Blue Shield of Michigan and Blue Care Network will process and pay otherwise covered claims as though the premium had been paid.
- For claims with dates of service during the next two months, BCBSM and BCN will pend claims for members who are receiving the Advanced Premium Tax Credit and are delinquent with premium payments.
    - If the member pays the premium payment in full by the end of the grace period, BCBSM and BCN will process the pended claims in accordance with the member's benefits.
    - If the member fails to pay by the end of the grace period, their coverage will be terminated effective the end of the first month of the grace period. All claims that are pended during months two and three will be rejected as "member ineligible".

Here are the direct impacts to health care providers:

- During the months two and three of the grace period, providers will see the special message noted above on the first web-DENIS eligibility screen. When this happens, providers may require these members to make payment in full at the time a covered service is rendered, up to BCBSM's (or BCN's) allowed amount.
- If the member pays the premium in full before the end of the third month of the grace period, the Blues will pay the pended claims to the provider. The provider will then need to refund the member any payments for covered services in excess of the liability communicated on the remittance advice (within 60 days, as per BCBSM and BCN policy).

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GRACE PERIOD continued from Page 6

Because this **only** applies to members who purchase health insurance through the Health Insurance Marketplace and receive a federal premium subsidy, you won't see this until 2014. However, we wanted to be sure you were aware of the change in advance. We'll continue to provide updates on issues related to reform.

The information in this article does not apply to pharmacy providers.

Continue to watch The Record and BCN Provider News for more reform information in the upcoming months.

Blues to offer national health reform webinars

Blue Cross Blue Shield of Michigan and Blue Care Network will offer webinars about national health care reform for providers in October, November and December.

The webinars will be held from 10 to 11:30 a.m. on the following dates:

- Oct. 17 and 29
- Nov. 12 and 21
- Dec. 5 and 12

The webinars will cover the basics of health reform and how it impacts health care providers, employees and taxpayers.

To register, send an email to jholzhausen@bcbsm.com with "NHR Webinar" and the date in the subject line. You will receive additional information by email.

Web-DENIS enhancements enable physicians to identify patient gaps in care

To help identify gaps in patient care, we have enhanced web-DENIS. Now, when physicians or health care professionals click on a member care alert, they'll be brought to a page in web-DENIS that will display a printable list of diagnosis gaps and treatment opportunities by patient.

Primary care physicians
When you click on a diagnosis gap or treatment opportunity on the list, you'll be brought to the Health e-Blue[SM] home page, if you have access. Once in Health e-Blue, if the patient is in your panel, you may navigate to the *Diagnosis Evaluation* panel or *Treatment Opportunities by Condition/Measure* panel to close patient gaps.

If you don't have access to Health e-Blue, you can download an application from **bcbsm.com/providers.**

- Click on *Provider Secured Services*.
- Under *Solutions available through Provider Secured Services*, click on *Health e-Blue[SM] for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data*.
- Under *How Do I Sign Up*, click on *Health e-Blue Application and the Use and Protection Agreement (PDF)*.

Specialists and other health care providers
If you aren't eligible for access to Health e-Blue, you can still close patient gaps by providing the service and billing for that service on a claim. Check out **bcbsm.com/providers** for a list of provider types who are eligible for access.

- Click on *Provider Secured Services*.
- Under *Solutions available through Provider Secured Services*, click on *Health e-Blue[SM] for Blue Care Network patient data and Blue Cross Blue Shield of Michigan Medicare Advantage patient data* to view a list of provider types who are eligible for access.

- **Diagnosis gap**: A suspected or historical condition that hasn't been documented and coded in the current calendar year or hasn't been confirmed as not applicable to the member.
- **Treatment opportunity**: A preventive service or treatment needed by the member, measured according to Healthcare Effectiveness Data and Information Set quality indicators.

WEB-DENIS continued on Page 8

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New member gap details screen

Member: Joe Doe

Contract# 987654321

Diagnosis Gaps ID	Status	HCC Code	HCC Description	ID Type	Edit
1		80	Congestive Heart Failure	CLAIMS	Link to Update
2		105	Vascular Disease	Possible Condition	Link to Update
3	✓	15	Diabetes with Renal or Peripheral Circulatory Manifestation	Previously Reported	Link to Update

Treatment Opportunities:

Treatment Opportunity ID	Status	Service Type	Last Service Date	Last Service Result	Service Needed By	Edit
1		Colorectal Screening	1/1/2013	4.5	1/1/2014	Link to Update
2		Pneumonia Vaccine	1/1/2012	24.7	1/1/2013	Link to Update
3	✓	Monitoring for Persistent Meds: ACE Inhibitor/ARB	1/1/2013	0.8	1/1/2014	Link to Update

= Not Met
= Pending Met
✓ = Met

BCBSM Medicare Advantage PPO physicians and Blue Care Network primary care physicians will see a list of diagnosis and treatment opportunity gaps by patient, with a status symbol indicating whether diagnosis gaps are open, pending or closed. Treatment opportunity gaps will be listed as not met, pending met or met.

Open Gap | Gap Closure Pending | Previously Confirmed Gap

The Member Care Alert buttons will appear for BCN commercial and Medicare Advantage patients and BCBSM Medicare Advantage patients covered under the following products: BCBSM Medicare Plus Blue PPO℠, BCN Advantage℠ and BCN commercial. Diagnosis gaps will only be available for Medicare Advantage patients.

See the previous article about the new member care alert buttons in the July edition of *The Record*. The color-coded buttons were added to the web-DENIS member eligibility screen in July to quickly assist physicians in identifying patient needs.

The alert buttons are color-coded as follows:

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

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

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

If you have questions regarding these enhancements, please contact your BCBSM provider consultant or BCN provider affairs representative.

Blues to launch Electronic Provider Access tool

As part of our ongoing efforts to make it easier for you to do business with us, we're launching a new tool Jan. 1, 2014, that will give you access to other Blue plan provider portals for the out-of-state members you treat.

The Electronic Provider Access tool will allow you access in order to conduct electronic preservice reviews, including prenotification, precertification, preauthorization and prior approval. It also will give health care providers outside of Michigan access to the BCBSM provider portal for electronic preservice reviews.

Please note that Blue Care Network will not be launching the tool until later in 2014.

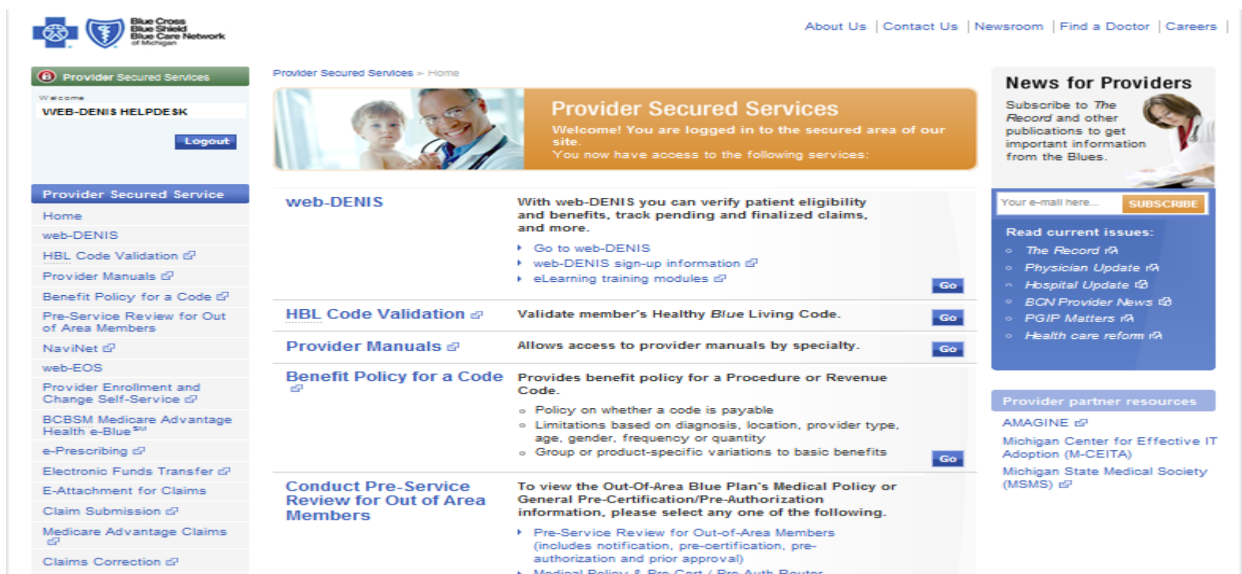
With this tool, you'll use Provider Secured Services to gain access to a member's home plan provider portal through a secure routing mechanism. Once in the out-of-state Blue plan's provider portal, you'll have the same access to electronic preservice review capabilities as that Blue plan's local providers.

The availability of Electronic Provider Access on Jan. 1, 2014, will vary depending on the capabilities of each out-of-state member's Blue plan at that time. Some plans may have fully implemented this tool's capabilities, others may only allow preservice review for certain services, and others may not have implemented any electronic preservice review capabilities.

The following describes how to use Electronic Provider Access and what to expect when attempting to contact plans at different stages of implementation.

How do I get started using this tool?

The first step for health care providers is to go to the BCBSM website and log in. You will then select the *Conduct Pre-Service Review for Out-of-Area Members* menu option. See screen shot below.



Next, you will be asked to enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member's ID number.

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Logout

You may request a pre-service review. Please enter the NPI and the Alpha Prefix, which is the first three letters of the member's identification number on the Blue Cross Blue Shield ID card, and click "Request Pre-Service Review".

All fields marked with (*) are required.

*Enter NPI:

*Enter AlphaPrefix:

Request Pre Service Review | Back

Have Questions? For technical assistance, call the BCBSM Web Support Helpdesk at 1-877-258-3932.
For all other questions, call BCBSM's Provider Inquiry Operations area at 800-482-0898. |Privacy Policy

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Please note that you can check first whether precertification is required by the member's home plan by:

- Sending a service-specific request through BlueExchange
- Accessing the home plan's precertification requirements pages by using the Medical Policy/Pre-Auth Router.
  - Log in to Provider Secured Services.
  - Go to the *Conduct Pre-Service Review* for *Out of Area Members* section of the page.
  - Click on *Medical Policy & Pre-Cert/Pre-Auth Router.*

What will happen once I am routed to the home plan provider portal?
Entering the member's alpha prefix for preservice review will automatically route you to the home plan's Electronic Provider Access landing page. This page will welcome you to the Blue plan portal and indicate that you have left BCBSM's portal. The landing page will allow you to connect to the available electronic preservice review processes.

Because the screens and functionality of a plan's preservice review processes vary widely, home plans may include instructional documents or e-learning tools on the landing page to provide instructions on how to conduct an electronic preservice review. This page will also include instructions for conducting preservice review for services where the electronic function is not available.

The home plan's landing page will look similar across Blue plans, but will be customized to the particular home plan based on the electronic services the plan offers.

Are there situations in which I will not be routed to the member's home plan?
In some instances, you'll receive an error message when you enter the alpha prefix. This error message may indicate that you have not entered the appropriate number of alpha prefix characters or that the alpha prefix is inactive. (The alpha prefix may become inactive if a group with a unique alpha prefix moves to another carrier or plan.) If you encounter this error, please be sure to verify the three-letter alpha prefix on the patient's ID card.

ACCESS TOOL continued on Page 11

ACCESS TOOL continued from Page 10

In other cases, you will receive a message with further instructions for conducting preservice review. For example, a provider may receive the following alert if they attempt to enter an alpha prefix for a Kansas City member:

"Blue Cross and Blue Shield of Kansas City does not currently conduct electronic preservice reviews. Please call 555-555-5555 for preservice review."

Note regarding Federal Employee Program members: Federal employee contract numbers, which begin with the letter "R" and don't include a three-letter alpha prefix, are not supported by Electronic Provider Access.

What if I enter the alpha prefix and nothing happens?
We hope that these situations are infrequent as we work through early implementation issues. But if this should happen, providers can always call 1-800-676-BLUE to be routed to a plan for telephone preservice review.

If you have any questions about the EPA tool, please contact your provider consultant.

AIM Specialty Health[SM] updating its appropriateness guidelines

AIM Specialty Health, our radiology partner, has announced updates to its *Clinical Appropriateness Guidelines*. The changes, which will be implemented Nov. 4, will impact high-tech radiology services. These include CT scans, MRIs and nuclear cardiology tests, as well as PET and echocardiography exams.

Blue Cross Blue Shield of Michigan is reviewing the screening guidelines for CT scans for lung cancer patients and will issue a policy statement later this year.

We've posted the updated guidelines on web-DENIS. To find the guidelines:

- Go to web-DENIS.
- Click on *BCBSM Provider Publications and Resources.*
- Click on *Newsletters and Resources.*
- Click on *Clinical Criteria & Resources* on the left navigation bar.
- Click on *AIM Specialty Health 2013 diagnostic imaging clinical guidelines.*

Benefit maximums will be more accurately reported in 835 remittance files

Starting November 2013, we will distribute enhanced NASCO 835 electronic remittance advice transactions.

The enhancements to the NASCO 835 files will make it easier to identify a member's liability amount when his or her benefit maximum has been exceeded. Professional and Institutional 835s will now report the liability amount in Loop 2100 or Loop 2110 CAS segments:

How a CAS segment looks today	How a CAS segment will look as of November
CAS*PI*119 (PI = Payer initiated)	CAS*PR*119 (PR = Patient responsibility)

To assist with patient account reconciliation, members' explanation of benefits will also include a line that identifies the benefit excess. Members will be responsible for paying the excess to the provider.

If you have questions regarding this information, please call the Electronic Data Interchange Help Desk at 1-800-542-0945.

Providers of outpatient abortion services must comply with new state law to receive reimbursements

Providers who advertise outpatient abortion services and perform more than 120 abortions in their offices in a year are required by law to be licensed as a freestanding outpatient surgical facility. This requirement is the result of Public Act 499 of 2012, which took effect March 31, 2013. The law also creates additional requirements and provisions for performing abortion services.

Blue Cross Blue Shield of Michigan will not pay for covered abortion services if providers fail to comply with Public Act 499 of 2012. We will attempt to recover all reimbursements paid to the provider during the time the provider is out of compliance. In addition, the provider's participation agreement may be terminated.

Physicians operating freestanding outpatient surgical facilities under this law are not necessarily part of the Blue Cross ambulatory surgical facility provider class and would have to apply to participate as an ambulatory surgical facility. Otherwise, physicians performing abortion services in these settings should continue to bill BCBSM as a physician office location.

Please contact your provider consultant if you have any questions.

The information in this article is not intended to provide legal advice. If you have any legal questions about this subject, you should consult your attorney or other professional legal services provider.

Keep in mind these coding tips to improve medical record documentation

This article is part of a series on coding tips.

Last month's article in this series focused on accurate documentation for diabetes and its manifestations. This month, we're taking a look at the correct coding for renal, ophthalmic, neurological and peripheral circulatory manifestations of this complex condition.

Common documentation and coding challenges for diabetic 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 a primary diabetes code.
- The wrong manifestation code is reported for the condition.

Selection of manifestation codes
A common coding error for diabetes is the selection of the wrong manifestation code. In some cases, the code reported when the condition is a manifestation of diabetes isn't the same code that's reported when the condition exists independently.

This is an easy distinction for a coder to make by referencing the alphabetic index or tabular of ICD-9-CM, but providers who select their own codes through search engines in an electronic medical record will often select the wrong code for the manifestation.

For example, idiopathic progressive polyneuropathy is coded as 356.4 if it's the patient's primary condition. However, if the patient has polyneuropathy due to diabetes, it's coded as 357.2 (polyneuropathy in diabetes).

Tips for diabetes with renal manifestations – 250.4x

Manifestation	Code/Code Range
Chronic kidney disease, Stages I-V	585.1-585.5
End-stage renal disease	585.6 Use additional code: V45.11 (patient on dialysis) V45.12 (non-compliant with dialysis)
CKD, unspecified	585.9
Nephropathy NOS	583.81
Nephrosis, intercapillary Glomerulosclerosis (Kimmelstiel-Wilson syndrome)	581.81

Code 250.4x, followed by the appropriate manifestation code for diabetes with renal manifestations:

- When documentation states diabetic nephropathy or diabetic nephritis, not specified as acute or chronic, code 583.81 as the manifestation.

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- When reporting codes for chronic kidney disease (585.1-585.5), the specific stage of the disease must be stated in the documentation. CKD stages cannot be coded based on the glomerular filtration rate.
- Code 581.81 if documentation indicates intercapillary glomerulosclerosis, also known as Kimmelstiel-Wilson disease. The same code is also used for nephrosis or nephrotic syndrome, which refers to a degenerative disease of the renal tubules.
- If documentation indicates both a stage of CKD and end-stage renal disease, report code 585.6 only

Tips for diabetes with ophthalmic manifestations – 250.5x

Manifestation	Code/Code Range
Blindness	369.00-369.9
Cataract	366.41
Glaucoma	365.44
Macular edema and retinal edema	362.07
Retinopathy	362.01-362.07

Code 250.5x, followed by the appropriate manifestation code for diabetes with ophthalmic manifestations:

- The code for macular or retinal edema, 362.07, cannot be used without one of the codes for diabetic retinopathy. Diabetic macular edema is only present with diabetic retinopathy.
- Use caution when selecting a cataract code. There's a difference between a diabetic cataract (366.41) and a senile cataract (366.10-366.19). Only a diabetic or "snowflake" cataract can be classified as a manifestation of diabetes.

Tips for diabetes with neurological manifestations – 250.6x

Manifestation	Code/Code Range
Amotrophy	353.5
Gastroparalysis and gastroparesis	536.3
Mononeuropathy	354.0 – 355.9
Neurogenic arthropathy (Charcot Joint)	713.5
Peripheral autonomic neuropathy	337.1
Polyneuropathy	357.2

Code 250.6x, followed by the appropriate manifestation code for diabetes with neurological manifestations:

- Documentation specifying "diabetic peripheral neuropathy" or "loss of protective sensation" due to diabetes should be assigned to polyneuropathy, code 357.2. This is the most common form of diabetic neuropathy, affecting the feet, legs and sometimes the hands and arms.
- Autonomic neuropathy affects the autonomic nervous system, which controls the heart, bladder, lungs, stomach, intestines, sex organs and eyes. Many conditions are attributed to autonomic neuropathy and should be reported with 337.1, and the code for the autonomic manifestation, if specified:
  - Gastroparesis and gastroparalysis: 536.3.
  - Orthostatic hypotension: 458.0.
- Report 353.5 for diabetic amyotrophy, also known as radiculoplexus neuropathy, femoral neuropathy or proximal neuropathy. This condition affects nerves in the thighs, hips, buttocks or legs.
- Report the appropriate code from 354.0 – 355.9 for mononeuropathy, also known as focal neuropathy. This condition involves damage to a specific nerve in the face, torso or leg. It can also occur when a nerve is compressed, like in the case of carpal tunnel syndrome.
- Code 713.5 for neurogenic arthropathy (charcot joint), which occurs when a joint deteriorates because of nerve damage, usually in the ankle or foot.
- For ulcers caused by diabetic neuropathy, report the appropriate manifestation code, followed by a code from 707.1 – 707.19 for the ulcer. If gangrene is present, also code 785.4.

Tips for diabetes with peripheral circulatory disorders – 250.7x

Manifestation	Code/Code Range
Peripheral angiopathy	443.81
Gangrene	785.4

Code 250.7x, followed by the appropriate manifestation code for diabetes with peripheral circulatory disorders:

- Peripheral vascular disease or peripheral arterial disease caused by diabetes is coded as 443.81 (peripheral angiopathy in diseases classified elsewhere).

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- Ulcers caused by peripheral vascular disease are reported with 443.81, and a code from 707.1 – 707.19 for the ulcer. If gangrene is present, also code 785.4.
- If documentation states atherosclerosis of the extremities due to diabetes, use code 440.2x.

Tips for diabetes with other specified manifestations – 250.8x

Code 250.8x, followed by the appropriate manifestation code for diabetes with other specified manifestations:

- Diabetic hypoglycemia or hypoglycemic shock is reported with 250.8x. No manifestation code is required for this condition.
- Code 250.8x if an ulcer is specified as diabetic, but documentation does not specify if it's due to peripheral vascular disease or polyneuropathy. Use an additional code from 707.10-707.19, 707.8 or 707.9 to identify the ulcer.
- For diabetic osteomyelitis, report 731.8 and a code from category 730.

Other tips for diabetes and ulcers

- If the ulcer is caused by a superimposed infection, it shouldn't be coded as a manifestation of diabetes. Not all ulcers in diabetic patients are related to the condition.
- Pressure ulcers, also known as decubitus ulcers, shouldn't be coded as a manifestation of diabetes.

These manifestation coding tips should also be followed when coding series 249 for secondary diabetes. Remember to code for the underlying disease or condition first, followed by a code from series 249.

Be sure to check out next month's edition of *The Record*, which will include an article about coding tips for chronic obstructive pulmonary disease.

Nothing in this article is intended to provide legal advice and, as such, it remains the responsibility of providers to ensure that all coding is done in accordance with applicable state and federal laws and regulations.

Reminder: Guidelines for collecting cost-sharing amounts

We want to remind providers that our participating agreements prohibit, except in certain circumstances, the waiving of member cost-sharing amounts. Offering discounts on member cost-sharing liability for prompt payment or for other reasons is prohibited.

The only permitted exception, as stated in our participation agreements, are for hardship cases that are documented in the member's records or when reasonable collection efforts have failed.

Our guidelines are as follows:

- Collecting cost-sharing amounts, such as copayments and deductibles, at the time of service, registration or admission, does not violate Blue Cross Blue Shield of Michigan's participation agreements as long as the amount collected is not more than the member's liability.
- For elective or routine services, health care providers may insist on payment of known member liabilities at the time of service, registration or admission.
- If it's later determined that there was an overpayment, providers must promptly refund the overpayment to the member.
- Providers are not permitted to mandate that members provide credit card information in order to secure any future balances. However, members may voluntarily choose to do so.

BCBSM makes information about member eligibility, benefits and cost-sharing available through web-DENIS and CAREN. Because a member's eligibility for coverage can change at any time, our provider participation agreements require providers to verify eligibility at the time of service or admission, even if previously verified.

To reiterate, based on our participation agreements, it's prohibited to waive member cost-sharing. This includes offering discounts for prompt payment or other reasons that reduce member liability.

It's important for providers to submit timely claims so that we can keep our member cost-sharing information as up-to-date as possible.

For more information, 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	
81228, 81229	**Basic Benefit and Medical Policy** The safety and effectiveness of chromosomal microarray analysis have been established. It may be considered a useful diagnostic option when indicated for patients meeting specific patient selection criteria. Policy updates effective July 1, 2013, include two additional procedures. **Group Variations** Not payable for MPSERS enrollees **Payment Policy** Not payable in an office location.
81235	**Basic Benefit and Medical Policy** The safety and effectiveness of analysis of two types of somatic mutation within the EGFR gene — small deletions in exon 19 and a point mutation in exon 21 (L858R) — have been established. They are an effective diagnostic option for predicting treatment response to erlotinib in patients with advanced non-squamous, non-small cell lung cancer, effective March 1, 2013. The analysis of 2 types of somatic mutation within the EGFR gene — small deletions in exon 19 and a point mutation in exon 21 (L858R) — is considered experimental for patients with advanced squamous cell-type NSCLC. **Continued on next page**

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NEW PAYABLE PROCEDURES	
81235 ***Continued***	The analysis for other mutations within exons 18-24 of the EGFR gene or other applications related to NSCLC is considered experimental. **Group Variations** Not payable for Chrysler and Delphi groups **Inclusionary Guidelines** The test is intended for use in patients with advanced NSCLC. Patients with either small deletions in exon 19 or a point mutation in exon 21 (L858R) of the tyrosine kinase domain of the epidermal growth factor gene are considered good candidates for treatment with erlotinib. **Exclusionary Guidelines** Patients found to be wild type are unlikely to respond to erlotinib. Other treatment options should be considered.
90875, 90876 ****90901**	**Basic Benefit and Medical Policy** Neurofeedback training as an alternative therapy for children with attention deficit hyperactivity disorder has been established. It may be a useful treatment option when indicated for children through 18 years of age, effective May 1, 2013. Neurofeedback training for other central nervous system disorders, such as autism spectrum disorder, substance abuse, epilepsy, and insomnia, is experimental. There is a lack of evidence in the peer reviewed published medical literature on the clinical utility and effectiveness of neurofeedback for these conditions. **Biofeedback was previously established for urinary and fecal incontinence treatment only. **Group Variations** Not payable for Chrysler, GM, Delphi, the Federal Employee Program®, MPSERS or URMBT groups. **Payment Policy** Payable to an M.D., D.O., fully licensed psychologist or C.L.M.S.W. Services are subject to all the rules and limitations of the member's mental health benefit. **Inclusionary Guidelines** • The patient is 18 years of age or younger with a confirmed DSM-IV diagnosis of ADHD. • Neurofeedback training is performed by a qualified, licensed health practitioner. **Exclusionary Guidelines** • All other central nervous system disorders • More than 40 neurofeedback sessions

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NEW PAYABLE PROCEDURES	
J0718	**Basic Benefit and Medical Policy** Injectable drug J0718 is reimbursable to a physician assistant.
UPDATES TO PAYABLE PROCEDURES	
27415	**Group Variations** Procedure code 27415 is payable for MPSERS, retroactive to Jan. 1, 2011. Payable to M.D. or D.O. Payable locations are inpatient, outpatient and ambulatory surgery facility.
77058, 77059	**Basic Benefit and Medical Policy** Magnetic resonance imaging for the assessment of silicone breast implants may be considered established in specified situations, effective Sept. 1, 2013. **Group Variations** **Note:** Refer to member's certificate for benefit specific coverage of screening tests and procedures. (The PPO Radiology Management Program may apply.) **Inclusionary Guidelines** To confirm the clinical diagnosis of rupture of silicone breast implants **Exclusionary Guidelines** Monitoring the integrity of silicone gel-filled breast implants when there are no signs or symptoms of rupture
77424, 77425**, 77469** **Facility benefit only	**Basic Benefit and Medical Policy** The safety and effectiveness of intraoperative radiation therapy have been established for selected patients with specified cancers. Inclusionary and exclusionary guidelines have been updated, effective Dec. 1, 2012. **Group Variations** Not payable for GM and Delphi groups. For Ford, Chrysler and URMBT, service is based on individual consideration. **Inclusionary Guidelines** Established for the following recurrent or unresectable cancers without distant metastases, based on NCCN guidelines: • Rectal cancer: For patients with T4 or recurrent cancers with very close or positive margins after resection, as an additional boost • Colon cancer: For patients with T4 or recurrent cancers as an additional boost • Central pelvic recurrent cervical cancer after radiation therapy should be considered for pelvic exenteration with or without IORT **Continued on next page**

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UPDATES TO PAYABLE PROCEDURES	
77424, 77425**, 77469** **Facility benefit only ***Continued***	• Recurrent uterine endometrial adenocarcinoma in patients previously treated with external beam radiation at the site of recurrence • Soft tissue sarcomas **Exclusionary Guidelines** Considered experimental for all other indications.
A4604-A7039, A7046	**Basic Benefit and Medical Policy** Effective Feb. 1, 2013, BCBSM will align our policy with CMS to reflect the listed quantity and frequency restrictions for the listed positive airway pressure supplies. **Procedure Code** — **Quantity and Frequency** A4604 — 1 per 3 months A7027 — 1 per 3 months A7028 — 2 per 1 month A7029 — 2 per 1 month A7030 — 1 per 3 months A7031 — 1 per 1 month A7032 — 2 per 1 month A7033 — 2 per 1 month A7034 — 1 per 3 months A7035 — 1 per 6 months A7036 — 1 per 6 months A7037 — 1 per 3 months A7038 — 2 per 1 month A7039 — 1 per 6 months A7046 — 1 per 6 months
E0424, E0425, E0430, E0431, E0433-E0435, E0439-E0445, E1390-E1392, E1405, E1406, K0738 **Accessories** **A4606, A4608, A4619, A4620, A7525, A9900, E0455, E0580, E1353, E1354, E1356-E1358**	**Inclusionary Guidelines** Effective Jan. 1, 2014, BCBSM will adopt Medicare's coverage of oxygen and oxygen equipment rental for up to 36 months. After that time, suppliers, have to furnish the necessary supplies and accessories from the 37th month though the 60th month (five years) for the member without charging the member. After that time, a recertification can be performed and new equipment can be acquired if considered medically necessary.

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UPDATES TO PAYABLE PROCEDURES

Arm of Chair
E0973, E2209, K0015, K0017-K0020

Footrest or Legrest
E0951, E0952, E0990, E0995, E1020, K0037- K0047, K0050-K0053, K0195

Nonstandard Seat Frame Dimensions
E1011, E2201-E2204, K0056

Rear Wheels for Manual Wheelchairs
E0961, E0967, E0988, E2205, E2206, E2211- E2222, E2224-E2228, K0065, K0069- K0073, K0077

Batteries and Chargers
E2358-E2367, E2371, E2372, E2397, K0733

Power Seating Systems
E1002-E1010, E2301, E2310-E2313, E2321-E2331, E2373-E2378

Other Power Wheelchair Accessories
E1016, E1018, E2351, E2368-E2370, E2381-E2392, E2394-E2396, K0098

Miscellaneous Accessories
A9900, E0705, E0950, E0958, E0959, E0971, E0974, E0978, E0981, E0982, E0985, E1014, E1015, E1017, E1028-E1030, E1225, E1226, E2207, E2208, E2210, E2230, E2295, K0105, K0108

Basic Benefit and Medical Policy
The following reflects the inclusionary guidelines for wheelchair options and accessories:

> Options and accessories for wheelchairs are covered if the member has a wheelchair that meets BCBSM coverage criteria and the option or accessory itself is medically necessary. Coverage criteria for specific items are described below.

Arm of Chair
Adjustable arm height option (E0973, K0017, K0018 and K0020) is covered if the member requires an arm height that is different than that available using nonadjustable arms and the member spends at least two hours per day in the wheelchair.

An arm trough (E2209) is covered if the member has quadriplegia, hemiplegia or uncontrolled arm movements.

Footrest or Legrest
Elevating legrests (E0990, K0046, K0047, K0053 and K0195) are covered if:

1. The member has a musculoskeletal condition or the presence of a cast or brace which prevents 90-degree flexion at the knee; or
2. The member has significant edema of the lower extremities that requires an elevating legrest; or
3. The member meets the criteria for and has a reclining back on the wheelchair.

Nonstandard Seat Frame Dimensions
A nonstandard seat width or depth for a manual wheelchair (E2201-E2204) is covered only if the member's physical dimensions justify the need.

Wheels and Tires for Manual Wheelchairs
A gear reduction drive wheel (E2227) or a lever activated wheel drive (E0988) is covered if all of the following criteria are met:

1. The member has been self-propelling in a manual wheelchair for at least one year; and
2. The member has had a specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist or occupational therapist, or a physician who has specific training and experience in rehabilitation wheelchair evaluations and that documents the need for the device in the member's home. The PT, OT or physician may have no financial relationship with the supplier; and

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UPDATES TO PAYABLE PROCEDURES

Arm of Chair
E0973, E2209, K0015, K0017-K0020

Footrest or Legrest
E0951, E0952, E0990, E0995, E1020, K0037- K0047, K0050-K0053, K0195

Nonstandard Seat Frame Dimensions
E1011, E2201-E2204, K0056

Rear Wheels for Manual Wheelchairs
E0961, E0967, E0988, E2205, E2206, E2211- E2222, E2224-E2228, K0065, K0069- K0073, K0077

Batteries and Chargers
E2358-E2367, E2371, E2372, E2397, K0733

Power Seating Systems
E1002-E1010, E2301, E2310-E2313, E2321-E2331, E2373-E2378

Other Power Wheelchair Accessories
E1016, E1018, E2351, E2368-E2370, E2381-E2392, E2394-E2396, K0098

Miscellaneous Accessories
A9900, E0705, E0950, E0958, E0959, E0971, E0974, E0978, E0981, E0982, E0985, E1014, E1015, E1017, E1028-E1030, E1225, E1226, E2207, E2208, E2210, E2230, E2295, K0105, K0108

Continued

3. The wheelchair is provided by a supplier that employs a RESNA-certified assistive technology professional (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the member.

Batteries and Chargers
Up to two sealed batteries (E2359, E2361, E2363, E2365, E2371 and K0733) at any one time are allowed if required for a power wheelchair.

A non-sealed battery (E2358) will be reviewed retrospectively as not reasonable and necessary. Procedure codes E2360, E2362, E2364 and E2372 are covered by BCBSM.

A single mode battery charger (E2366) is appropriate for charging a sealed lead acid battery. If a dual mode battery charger (E2367) is provided as a replacement, it will be reviewed retrospectively as not reasonable and necessary.

The usual maximum frequency of replacement for a lithium-based battery (E2397) is one every three years. Only one battery is allowed at any one time.

Power Tilt or Recline Seating Systems
A power seating system — tilt only, recline only or combinations tilt and recline — with or without power elevating legrests will be covered if criteria 1, 2, and 3 are met and if criterion 4, 5 or 6 is met:

1. The member meets all the coverage criteria for a power wheelchair described in the BCBSM DME medical policy; and
2. A specialty evaluation that was performed by a licensed or certified medical professional, such as a physical therapist or occupational therapist or physician who has specific training and experience in rehabilitation wheelchair evaluations documents the member's seating and positioning needs. The PT, OT or physician may have no financial relationship with the supplier; and
3. The seating system is provided by a supplier that employs a RESNA-certified assistive technology professional (ATP) who specializes in rehabilitation wheelchairs and who has direct, in-person involvement in the selection of the seating system for the member; and
4. The member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or

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UPDATES TO PAYABLE PROCEDURES

Arm of Chair
E0973, E2209, K0015, K0017-K0020

Footrest or Legrest
E0951, E0952, E0990, E0995, E1020, K0037- K0047, K0050-K0053, K0195

Nonstandard Seat Frame Dimensions
E1011, E2201-E2204, K0056

Rear Wheels for Manual Wheelchairs
E0961, E0967, E0988, E2205, E2206, E2211- E2222, E2224-E2228, K0065, K0069- K0073, K0077

Batteries and Chargers
E2358-E2367, E2371, E2372, E2397, K0733

Power Seating Systems
E1002-E1010, E2301, E2310-E2313, E2321-E2331, E2373-E2378

Other Power Wheelchair Accessories
E1016, E1018, E2351, E2368-E2370, E2381-E2392, E2394-E2396, K0098

Miscellaneous Accessories
A9900, E0705, E0950, E0958, E0959, E0971, E0974, E0978, E0981, E0982, E0985, E1014, E1015, E1017, E1028-E1030, E1225, E1226, E2207, E2208, E2210, E2230, E2295, K0105, K0108

Continued

5. The member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to bed; or
6. The power seating system is needed to manage increased tone or spasticity.

If these criteria are not met, the power seating component(s) will be reviewed retrospectively as not reasonable and necessary.

Power Wheelchair Drive Control Systems
An attendant control is covered in place of a member-operated drive control system if the member meets coverage criteria for a wheelchair, is unable to operate a manual or power wheelchair and has a caregiver who is unable to operate a manual wheelchair but is able to operate a power wheelchair.

Other Power Wheelchair Accessories
An electronic interface (E2351) to allow a speech generating device to be operated by the power wheelchair control interface is covered if the member has a covered speech generating device. (Refer to BCBSM's Speech Generating Devices medical policy issues for details.)

Miscellaneous Accessories
Anti-rollback device (E0974) is covered if the member self-propels and needs the device because of ramps.

A safety belt or pelvic strap (E0978) is covered if the member has weak upper body muscles, upper body instability or muscle spasticity that requires use of this item for proper positioning.

One example (not all-inclusive) of a covered indication for swing away, retractable or removable hardware (E1028) would be to move the component out of the way so that a member can perform a slide transfer to a chair or bed.

A manual fully reclining back option (E1226) is covered if the member has one or more of the following conditions:

1. The member is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift; or
2. The member utilizes intermittent catheterization for bladder management and is unable to independently transfer from the wheelchair to the bed.

If these criteria are not met, the manual reclining back will be reviewed retrospectively as not reasonable and necessary.

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UPDATES TO PAYABLE PROCEDURES	
Arm of Chair E0973, E2209, K0015, K0017-K0020 **Footrest or Legrest** E0951, E0952, E0990, E0995, E1020, K0037- K0047, K0050-K0053, K0195 **Nonstandard Seat Frame Dimensions** E1011, E2201-E2204, K0056 **Rear Wheels for Manual Wheelchairs** E0961, E0967, E0988, E2205, E2206, E2211- E2222, E2224-E2228, K0065, K0069- K0073, K0077 **Batteries and Chargers** E2358-E2367, E2371, E2372, E2397, K0733 **Power Seating Systems** E1002-E1010, E2301, E2310-E2313, E2321-E2331, E2373-E2378 **Other Power Wheelchair Accessories** E1016, E1018, E2351, E2368-E2370, E2381-E2392, E2394-E2396, K0098 **Miscellaneous Accessories** A9900, E0705, E0950, E0958, E0959, E0971, E0974, E0978, E0981, E0982, E0985, E1014, E1015, E1017, E1028-E1030, E1225, E1226, E2207, E2208, E2210, E2230, E2295, K0105, K0108 ***Continued***	For information regarding a push-rim activated power assist device for a manual wheelchair, refer to the BCBSM DME medical policy. **Miscellaneous** The medical necessity for all options and accessories must be documented in the member's medical record and be available on request. This documentation might include information on why the member needs the item, the member's diagnosis, the member's abilities and limitations as they relate to the equipment (e.g., degree of independence or dependence, frequency and nature of the activities the member performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment. Accessories to the wheelchair base must be billed on the same claim as the wheelchair base itself. When billing option or accessory codes as a replacement, documentation of the medical necessity for the item, make and model name of the wheelchair base it is being added to and the date of initial issue of the wheelchair must be available upon request. **Group Variations** Procedure codes E2207 and E2351 are not covered for the Federal Employee Program®.
J0282	**Payment Policy** BCBSM will allow procedure code J0282 to quantity process with no maximum.
POLICY CLARIFICATIONS	
81211-81217, 88299	**Basic Benefit and Medical Policy** The safety and effectiveness of simultaneous testing for inherited BRCA1 and BRCA2 mutations have been established. It may be considered a useful diagnostic option when indicated for individuals at high risk of breast or ovarian cancer. Testing for genomic rearrangements of the BRCA1 and BRCA2 genes (e.g., BART testing) may be considered established in patients who meet criteria for BRCA1 and BRCA2 testing and whose testing for point mutations is negative. **Continued on next page**

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POLICY CLARIFICATIONS	
81211-81217, 88299 ***Continued***	Testing for CHEK2 genetic abnormalities (mutations, deletions, etc.) is considered experimental in affected and unaffected patients with breast cancer irrespective of the family history. Use of the BreastNext™ Next-Gen Cancer Panel and the OvaNext™ is experimental. There is insufficient data on the analytical and clinical validity as well as clinical utility of this testing on patient management and outcomes. Guidelines have been updated, effective May 1, 2013. **Inclusionary Guidelines** Please review the guidelines first to see if the patient falls into the high risk category for BRCA mutations, then apply the appropriate policy for affected (having a current cancer diagnosis) vs. unaffected patients (does not have a diagnosis of breast or ovarian cancer). **NCCN (2012) Guidelines for Family History Review and Background** Genetic cancer susceptibility is determined by a review of the patient's personal and family history. At least one of the following criteria must be present to be considered high risk for hereditary breast or ovarian cancer: • Individual from a family with a known deleterious BRCA1 or BRCA2 mutation • Personal history of breast cancer plus one or more of the following: – Diagnosed at an early age (≤45 years) – Diagnosed at age ≤50 years with at least one close blood relative** (see definition, following) with breast cancer at age ≤50 years or at least one close blood relative** with epithelial ovarian or fallopian tube or primary peritoneal cancer at any age – Two breast primaries when the first breast cancer diagnosis occurred prior to age 50 years – Diagnosed age <60 years with a triple negative breast cancer – Diagnosed age <50 years with a limited family history – Diagnosed at any age, with ≥2 close blood relatives** with breast or epithelial ovarian or fallopian tube or primary peritoneal cancer at any age – Close male relative** with breast cancer **Continued on next page**

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BENEFIT POLICY continued from Page 23

POLICY CLARIFICATIONS	
81211-81217, 88299 ***Continued***	– For an individual of ethnicity associated with higher mutation frequency (e.g., – Ashkenazi Jewish); no additional family history may be required • Personal history of epithelial ovarian or fallopian tube or primary peritoneal cancer • Personal history of male breast cancer • Personal history of breast or ovarian cancer at any age with >2 close blood relatives* with epithelial ovarian or fallopian tube or primary peritoneal cancer at any age • Personal history of pancreatic cancer at any age with >2 close blood relatives** with breast or ovarian cancer or pancreatic cancer at any age • Family history only: – Close blood relative** meeting any of the above criteria **A close blood relative typically refers to first-degree (parent, full sibling or offspring) and second-degree (grandparent, grandchild, uncle, aunt, niece, nephew or half-sibling) relatives in diseases associated with high-penetrance gene mutations, such as BRCA1 and BRCA2 mutations. Accommodation may be made to include third-degree relatives (first cousin, great grandparent or great grandchild) in some cases, e.g., limited family history, particularly in tracing hereditary breast and ovarian and related cancers in the paternal lineage. Certified genetic counselors or other qualified genetics professionals are best able to assess exceptional cases. The following guidelines for non-Ashkenazi Jewish women unaffected with cancer were derived by the USPSTF in 2005 after extensive literature review by the U.S. Preventive Services Task Force (USPSTF) : • Three or more first- or second-degree relatives with breast cancer, regardless of age at diagnosis; or • Two first-degree relatives with breast cancer, one of whom was diagnosed at age 50 years or younger; or • Combination of both breast and ovarian or fallopian tube or primary peritoneal cancer among first- and second-degree relatives; or • First-degree relative with bilateral breast cancer; or • A combination of two or more first- or second-degree relatives with ovarian or fallopian tube or primary peritoneal cancer regardless of age at diagnosis; or • A first- or second-degree relative with both breast and ovarian or fallopian tube or primary peritoneal cancer at any age; or

BENEFIT POLICY continued on Page 25

BENEFIT POLICY continued from Page 24

POLICY CLARIFICATIONS

81211-81217, 88299

Continued

- A history of breast cancer in a male relative.

The USPSTF guidelines do **not** address women affected with breast cancer.

Inclusionary Guidelines

Affected patient:

Genetic testing for BRCA1 and BRCA2 mutations in cancer-affected individuals may be considered established under any one of the following circumstances:

- Women who are affected with breast cancer or pancreatic cancer and are from families with a high risk of BRCA1 or BRCA2 mutation as defined in the guidelines, or
- Women who are affected with breast cancer or pancreatic cancer who are not from families with a high risk of BRCA1 or BRCA2 mutation as defined in the guidelines, but are affected with any of the following:
  - Early onset breast cancer (≤45 years) or
  - Two breast primary cancers with the first cancer diagnosis occurring prior to age 50 years, or
  - Triple negative breast cancer (neither express estrogen receptor and progesterone receptor, nor over express HER2) diagnosed at younger than age 60, or
  - Two or more close blood relatives** with pancreatic cancer of any age.
- Women affected with epithelial ovarian cancer or fallopian tube or primary peritoneal cancer
- Men affected with breast cancer at any age
- Those affected with breast cancer who are from an ethnic background, e.g., Ashkenazi Jewish descent, associated with deleterious founder mutations

Unaffected patients:

Genetic testing for BRCA1 and BRCA2 mutations of unaffected adults may be considered established under any of the following circumstances:

- Unaffected individuals (male or female) from families with a known BRCA1 or BRCA2 mutation
- Unaffected individuals from families with a high risk of BRCA1 or BRCA2 mutation based on a family history when the BRCA mutation status of affected family member is unknown (for any reason)

Continued on next page

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POLICY CLARIFICATIONS	
	• Unaffected individuals in populations at risk for specific founder mutations due to ethnic background (e.g., Ashkenazi Jewish descent) and with one or more relatives with breast, ovarian, fallopian tube or primary peritoneal cancer at any age Testing for genomic rearrangements of the BRCA1 and BRCA2 genes (BART testing) when the original BRCA testing did not include the BART test) may be considered appropriate in patients who meet criteria for BRCA testing, whose initial test for the BRCA gene is negative.
J3490	**Basic Benefit and Medical Policy** Injectafer (ferric carboxymaltose injection) is established when the FDA approved indications are met. The FDA approved Injectafer for the treatment of iron deficiency anemia in adult patients. This policy is effective July 25, 2013. Injectafer should be reported with not-otherwise-classified code J3490 until a permanent code is established. **Dosage and Administration** • Up to 750 mg can be delivered in a single dose. • Give two doses separated by at least seven days for a total cumulative dose of 1500 mg per course. • Administer intravenously by infusion over at least 15 minutes. • Slow push injection at the rate of approximately 100 mg (2 mL) per minute over at least 7.5 minutes. For patients weighing less than 50 kg (110 lb), give each dose as 15 mg/kg body weight. When administered via infusion, dilute up to 750 mg of iron in no more than 250 mL of sterile 0.9% sodium chloride injection, USP, such that the concentration of the infusion is not <2 mg of iron per mL and administer over at least 15 minutes. When administering as a slow intravenous push, give at the rate of approximately 100 mg (2 mL) per minute.
J3590	**Basic Benefit and Medical Policy** Kcentra (prothrombin complex concentrate, human) is established when the FDA-approved indications are met. The FDA approved Kcentra for the urgent reversal of anticoagulation in adults with major bleeding. This policy is effective April 29, 2013. Kcentra should be reported with not-otherwise-classified code J3590 until a permanent code is established. **Continued on next page**

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POLICY CLARIFICATIONS	
J3590 ***Continued***	**Dosage and administration for intravenous use only.** • Kcentra dosing should be individualized based on the patient's baseline ratio value and body weight. • Administer Vitamin K concurrently to patients receiving Kcentra to maintain factor levels, once the effects of Kcentra have diminished. • Repeat dosing with Kcentra is not supported by clinical data and is not recommended. • Administer reconstituted Kcentra at a rate of 0.12 mL/kg/min (~3 units/kg/min) up to a maximum rate of 8.4 mL/min (~210 units/min.). **Inclusionary Guidelines** Indicated for the urgent reversal of acquired coagulation factor deficiency induced by Vitamin K antagonist (VKA, e.g., warfarin) therapy in adult patients with acute major bleeding. **Exclusionary Guidelines** Kcentra is not indicated for urgent reversal of VKA anticoagulation in patients without acute major bleeding.
GROUP BENEFIT CHANGES	
County of Charlevoix	Effective Oct. 1, 2013, Medicare-eligible retirees of the County of Charlevoix 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 60348 with suffixes 601 and 602. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PPO plan, go to **bcbsm.com/provider/ma.**

HCPCS codes added

The Centers for Medicare & Medicaid Services has added four new Health Care Procedure Coding System codes as part of its regular quarterly HCPCS updates.

The new codes are listed below.

Code	Change	Coverage Comments	Effective Date
C1204	Added	Not covered by BCBSM	Oct. 1, 2013
C1841	Added	Not covered by BCBSM	Oct. 1, 2013
C9132	Added	Not covered by BCBSM	Oct. 1, 2013
G9187	Added	Not covered by BCBSM	Oct. 1, 2013

ALL PROVIDERS

Type of bill codes 32-34 changing Oct. 1

The National Uniform Billing Committee has changed the descriptions for type of bill codes 032 through 034 starting Oct. 1, 2013.

TOB code 033X is discontinued. Instead, codes 032X or 034X should be used when appropriate. The following chart shows the changes:

TOB Code	Description
032X	Home health services under a plan of treatment
033X	Home health outpatient (includes HHA visits under a Part A plan of treatment including DME under Part A) – **Discontinued**. This bill type will be rejected by the system.
034X	Home health services not under a plan of treatment.

For information about completing any of the locators on the claim form, please refer to your *UB-04 Manual*.

Critical Provider Issues identified on new web-DENIS site

Blue Cross Blue Shield of Michigan wants to keep health care providers informed about outstanding claims issues we're working to resolve. That's why we've developed the new *Critical Provider Issues* page on web-DENIS.

It identifies outstanding issues and provides progress updates, estimated completion date and direction on what to do with claims in the meantime. We encourage you to check this page before calling Provider Inquiry. Your answer may be there.

The information is available from the homepage of web-DENIS by clicking on the *Critical Provider Issues* link on the left side of the screen.

You'll also hear announcements for all critical issues when you select that option while on hold for Provider Inquiry.

PROFESSIONAL

ICD-10 testing for professional providers begins in October

With so many other changes going on in the industry, many people are putting the ICD-10 transition on the "back burner." However, this is a huge transition and one that everyone should begin now (if they haven't already).

BCBSM's ICD-10 testing tool for our **professional** health care providers will be available beginning in October 2013. Here are a few notes about the test tool:

- The test tool will be available starting in October 2013 and will continue through the ICD-10 implementation date of Oct. 1, 2014.
- Testing is done through a web-based assessment; no special software or lengthy test requirements will be needed.
- It is "content based" and "specialty specific," which means that professional health care providers will be presented with several medical scenarios and be able to code the scenarios in ICD-10
- Scenarios are based on specialties (internal medicine, oncology, etc.) and providers will need to register for each specialty they are interested in testing

For more information about testing, or to initiate the registration process, send an email with contact information to icd-10providertesting@bcbsm.com.

Board certified behavioral analyst training offered

We want to make sure that you have the tools you need to do business with us, so we've scheduled a training class for board certified behavioral analysts on Monday, Oct. 28.

We hope you'll be able to join us for this informative session. Here are the details:

- **Location:** Conference rooms A and B at the BCBSM Lyon Meadows Conference Center, 53200 Grand River Ave., New Hudson
- **Time:** 9 a.m. to 12 p.m.

To register, email SEprofessionaleducationregistration@bcbsm.com. You'll receive a confirmation within 72 hours of registering. It's important to register so that we may contact you in the event that the class is rescheduled or is cancelled.

Additional classes may be offered, and we'll publish that information in future issues of *The Record*.

For more information, please contact your provider consultant.

Change in reporting codes for professional urgent care services

Health care providers should report the add-on procedure code S9088 in location 22 (outpatient), with a $0 charge, for members who have the professional urgent care services benefit. This change is effective on or after April 1, 2013, and it applies to both electronic and paper CMS-1500 claim formats.

Procedure code S9088 is not separately payable and should be reported in addition to the appropriate office visit code: *99201-*99205 or *99211-*99215.

Don't report this add-on urgent care service code for professional services performed in the outpatient location that aren't for urgent care. In addition, only professional charges should be submitted.

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Hospital Outpatient Pricing Strategy II project begins Oct. 1

The HOPS II project will be implemented Oct. 1, 2013, which means it's important that providers remember to bill the appropriate revenue codes, as well as the correct Current Procedural Terminology and Health Care Common Procedure Coding System codes, for services provided to our members in a hospital outpatient location.

These changes also apply to BCBSM freestanding outpatient physical therapy facilities and to ambulatory surgery facilities (for services reported with revenue code 0730).

For more details, refer to previously published articles on this topic in *The Record* and *BCN Provider News*. You may want to check out the article titled, "Changes to hospital outpatient services reimbursement delayed," which ran in the March *Record*.

BCBSM offers inpatient documentation, coding accuracy training

Blue Cross Blue Shield of Michigan is offering online training to assist with inpatient documentation and coding accuracy. We want to help our hospitals by aligning their documentation with reportable diagnoses in accordance with the Centers for Medicare & Medicaid Services requirements.

These improvements in documentation and coding accuracy will ensure better quality peer comparisons, population management, risk scores, reimbursement and incentive distribution.

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TRAINING PRESENTATION continued from Page 29

The training is available on web-DENIS:

- Log in to web-DENIS.
- Click on *BCBSM Provider Publications and Resources*.
- Click on *Newsletters and Resources*.
- In *Provider Training* or the *What's New* section, under *Inpatient Coding Initiative presentation*, click on your preferred format.

For your convenience, the presentation is also available for viewing on your smart phone or tablet.

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

New occurrence code 55, condition codes 81-83 added for facility claims

The National Uniform Billing Committee is adding three new condition codes on Oct. 1, 2013, and one new occurrence code.

- Occurrence code 55 — Date of death (form locaters 31-34)
- Condition code 81 – C-sections or inductions performed at less than 39 weeks gestation for medical necessity
- Condition code 82 – C-sections or inductions performed at less than 39 weeks gestation electively
- Condition 83 – C-sections or inductions performed at 39 weeks gestation or greater

Condition codes are reported on the UB-04 claim in form locator 18-28. For information about completing any of the locators on the claim form, please refer to your *UB-04 Manual*.

Reminder: Changes in definitions for value codes Y1 through Y5

The National Uniform Billing Committee wants to remind you about the following changes to the definitions of value codes Y1 through Y5. These changes were made April 1, 2013.

Y1– Part A Demonstration: This is the portion of the payment designated as reimbursement for Medicare Part A services under the demonstration model claim.

Y2 – Part B Demonstration Payment: This is the portion of the payment designated as reimbursement for Medicare Part B services under the demonstration model claim. No deductible or coinsurance has been applied.

Y3 – Part B Coinsurance: This is the amount of Medicare Part B coinsurance applied by Medicare Part A & B Medicare Administrative Contractors to this demonstration model claim.

Y4 – Conventional Provider Payment: This is the amount Medicare would have reimbursed the provider for Part A services if there had been no demonstration model claim.

Y5 – Part B Deductible: This code was added April 1, 2013, as part of BCBSM's billing guidelines. This code indicates the amount of Part B deductible applied by administrative contractors to this demonstration model claim.

Value codes are reported in form locator 39-41 of the UB-04 Claim Form. For information about completing any of the locators on the claim form, refer to your *UB-04 Manual*.

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

Please remember that 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.

As we explained last month, this is part of our 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.

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.
- To submit electronic claims (ANSI 837P), report the information in the table below:

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

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PROFESSIONAL, DME, PHARMACY

NDC continued from Page 31

- 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.

PHARMACY

Are you billing correctly for these drugs?

The following drugs are often billed with incorrect quantities under the prescription drug benefit. We’ve listed the correct quantities for these drugs so your claims can be processed on time and more accurately. Please ensure that you submit the appropriate quantities on claims for all medications.

We’ve identified these drugs by their names, strength and frequently billed incorrect quantity. We’ve also listed the correct quantity that should be billed to us.

Drug name	Incorrect billed quantity	Correct billed quantity
Androgel® pump Example: 88 g pump delivering 75 g gel	Size of pump – 88 g	Amount of gel – 75 g
Premarin® vaginal cream Example: 0.635 mg/g, 30 g tube	42.50 g	Actual amount of cream – 30 g
Avonex Kit® Example: 30 mcg/0.5 mL, four prefilled syringes	Number of syringes – 4	Number of kits – 1
Clobex® Example: 0.05%, 118 mL lotion	120 mL	Actual amount of lotion – 118 mL
Enbrel® Example: 50 mg/0.98 mL, four prefilled syringes	Number of syringes – 4	Total Volume - 3.92 mL (4 x 0.98 mL)
Lovenox® Example: 40 mg/0.4 mL, one syringe	Number of syringes – 1	Volume – 0.4 mL
Pint bottles of liquids (e.g. promethazine-codeine, etc.)	480 mL	473 mL
Pregnyl® kit Example: 10000 IU, 10 mL vial	Volume – 10 mL	Number of kits – 1

For any questions on how to submit claims, contact our claims processor Express Scripts at 1-800-922-1557. For any unresolved issues or questions regarding the information in this article, contact our Pharmacy Services Clinical Help Desk at 1-800-437-3803.

Policy change regarding durable medical equipment rentals becomes effective Jan. 1, 2014

Effective Jan. 1, 2014, Blue Cross Blue Shield of Michigan will consider the effective date for durable medical equipment rentals to be the date that the member accepted delivery of the equipment — regardless of what health care carrier they had or if they had insurance at all at that time. This policy only applies when the health care carrier changes and the medical equipment supplier remains the same.

When a member's carrier changes to Blue Cross during a DME rental period, providers will be required to continue the rental based on the original effective date for billing purposes and report the appropriate modifier.

See the chart below:

Modifier	Description
KH	DME point of service: initial claim, purchase or first-month rental
KI	DME POS: second or third month rental
KJ	DME POS: fourth to 13th month rental

For capped rental items, we do not reimburse DME providers for rental payments that exceed the purchase price of each patient's equipment. Blue Cross will continue to pay for rentals using a 10-month rent-to-purchase timeframe.

For example:

A member has another health care carrier that reimburses for two months of rental for an item for which payment is capped at the purchase price. The DME provider must consider the amount previously paid with the other carrier when calculating additional billings to Blue Cross. If we determine that more was paid for the total rental period than the Blue Cross-approved purchase price of a capped item, we will initiate a recovery.

This policy also applies when a member's coverage switches from a narrow network to a broader network and the provider is a member of both networks.

If you have questions about this policy, contact your provider consultant or refer to your billing manual on web-DENIS.

GM establishes benefits coverage to treat autism spectrum disorder

General Motors' health plan for active salaried employees now offers benefit coverage for certain services used to treat autism spectrum disorder. The coverage, which took effect July 1, 2013, is for eligible dependents up to age 18.

These benefits will be covered by both Blue Cross Blue Shield of Michigan and ValueOptions®. Blue Cross will handle payments for services related to physical, occupational, speech and nutritional therapies. ValueOptions will handle mental health services.

GM employees will be subject to deductibles, coinsurance and out-of-pocket maximums for these services. **To verify what is covered under GM's mental health benefits, please call ValueOptions at 1-800-235-2302.**

@HOMe Support Program pilot begins for Medicare Advantage members

Medicare Plus Blue[SM] PPO members living in southeast Michigan and BCN Advantage[SM] members living in the Saginaw, Flint, Bay City or Midland areas who have been diagnosed with advanced or terminal illness may participate in a pilot program designed to provide them with specialized health care services and support.

The @HOMe (At Home) Support Program pilot started in August 2013 and ends December 2015.

A subsidiary of Hospice of Michigan, the program focuses on supporting members with advanced illness, their families and caregivers in the home by providing home-based clinical services, including coordination of care, assessment and counseling associated with advanced illness, informed decision-making and 24/7 phone access to a registered nurse.

@HOMe support staff members have extensive training in palliative management. Copayments for members receiving home care service by @HOMe Support are waived.

Disease-specific criteria include the following:

- Cancer: Any Stage IV disease
- CHF: New York Heart Association Stage III or IV
- COPD: GOLD Stage III or IV
- Debility: Multiple comorbid conditions contributing to declining status and limited life expectancy

The Blues identifies members based on claims and pharmacy data. Members may opt out of the program.

While there are no direct physician referrals to this program, if you have a Medicare Plus Blue PPO member who may benefit from this program, you may encourage them to call the servicing number on the back of their ID card to request more information.

Clarification: Medicare Advantage enhanced benefit fee schedule to be updated in November

An article that appeared in the September issue of *The Record* should have said that the Blue Cross Blue Shield of Michigan Medicare Advantage enhanced benefit fee schedule will be updated in **November** 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 facility and non-facility locations. The fee schedule will not include incentive amounts.

Physician payments for Medicare Advantage enhanced benefits will be reduced, starting Nov. 6, 2013. The enhanced benefit fee schedule on **bcbsm.com/provider/ma** will be updated on this date.

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

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 (hospitals)	1-800-228-4599
(facilities)	1-800-437-3804
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 (professional)	313-225-7778
(facilities)	313-225-0914
West Michigan	616-389-8141
Mid Michigan	517-324-4590
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 American	1-888-826-8152
Blue Care Network	1-800-255-1690
Blue Choice® Point of Service	1-877-285-0172
BlueCard®	1-800-676-2583
Michigan State Medical Society	517-337-1351
Michigan Osteopathic Association	517-347-1555
Michigan Health & Hospital Association	517-323-3443
Web-DENIS	1-877-258-3932

Electronic Claims Submission

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

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