November 2013

Articles in this issue…

We're moving to an all-electronic format for *The Record*

As you may have read in our October issue, we're discontinuing the print version of *The Record*, effective with the February 2014 issue. The January 2014 issue of the newsletter is the last print edition you will receive.

Moving to a completely electronic *Record* is part of our commitment to give you access to the news and information you need as quickly as possible. 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 on Oct. 31 — several days before print edition subscribers received their 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 the topic that reflects your main area of interest (for example, Professional, Facility or Pharmacy) and to indicate your work area (for example, billing service, hospital, etc.)
- Be sure to scroll down and click on the *Subscribe* button.

Current and archived issues of the electronic version of *The Record* also can be easily accessed from **bcbsm.com/providers**. Simply click on the *Newsletters* tab and then *The Record 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 stop mailing paper remittance advices Dec. 6

Blue Cross Blue Shield of Michigan and Blue Care Network will stop printing and mailing paper remittance advices (also known as vouchers) to Michigan health care providers Dec. 6, 2013, with the exception of BCBSM local facility remittance advices, which will continue to be mailed.

The move to online remittance advices helps us align with federally mandated electronic funds transfer and electronic remittance advice requirements. These rules are components of the administrative simplification provisions specified in the Affordable Care Act. This part of health care reform is designed to:

- Reduce administrative costs
- Enhance the ease of doing business between insurers and health care providers
- Promote the growth of online recordkeeping

Note regarding out-of-state providers: BCBSM also will stop mailing remittance advices to participating out-of-state providers on Dec. 6; however, out-of-state providers who are paid through the Medicare crossover process will continue to receive paper remittance advices. And BCN will continue to mail paper remittance advices to out-of-state providers until mid-2014.

Action steps for paper remittance advice users
All providers in the state of Michigan and those outside the state who have a contract with BCBSM or BCN should follow these steps:

1. If you do not have access to Provider Secured Services, sign up today at **bcbsm.com/providers**. You must register every national provider identifier and the associated BCBSM PINS for which you submit claims. **You will not be able to receive electronic payments or view online remittance advices for claims billed with an NPI that is not registered or for claims associated with a BCBSM PIN that is not linked to your NPI.**
2. If you are already registered for Provider Secured Services, but need to add some NPIs or need to link some BCBSM PINs to current NPIs, you need to complete one of these forms:
   - Providers complete *Authorization to Modify Provider Codes (PDF).*
   - Billing services complete *Addendum "B" Authorization for Representative Access (PDF)*.
3. Go to **bcbsm.com/vouchers** for the steps to access up to three years of remittance advice history. You'll have the ability to search by check number, EFT trace number, period of time or patient name.
4. If you still receive paper checks, sign up for electronic funds transfer. Please note that you must first register for Provider Secured Services before registering for EFT. Not all BCBSM hospitals and facilities have access to EFT today, but will be able to register for EFT starting Dec. 6, 2013. When you complete the EFT registration process, make sure to register every NPI you use and the BCBSM PINs associated with each NPI. If you have some NPIs or BCBSM PINs that are not registered for EFT, you will need to register these NPIs. To register for the first time — or to add NPIs — follow these steps:
   - Go to **bcbsm.com/providers** and log in.
   - Scroll down to *Electronic Funds Transfer* and click on *Register Provider*.
   - Complete the information and click *Submit.*

Please allow three to five weeks for processing. Once the registration process is complete, all funds for the registered NPI (or PIN) will be sent electronically.

We encourage professional health care providers and hospitals or facilities that currently do not access Provider Secured Services to enroll as soon as possible. This will ensure that your staff has the access needed on or after Dec. 6, 2013, to enroll for EFT or be able to view the vouchers online when they're no longer provided on paper.

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.

Changes to Electronic Remittance Advice and Electronic Funds Transfer take effect Jan. 1 2014

You may be aware of the Affordable Care Act and the changes relating to patients and businesses, but you may not know that the ACA also affects the electronic Health Information Portability and Accountability Act standard transactions.

The ACA has defined mandated operating rules through the Council for Affordable Quality Healthcare and the Committee on Operating Rules for Information Exchange that will augment the current HIPAA standard transaction guidelines. For more information on these guidelines, go to **caqh.org/CORE_overview.php**.

Two of the operating rules that specifically relate to the HIPAA-mandated 835/ERA standard transaction are CORE 382 ERA Enrollment Data Rule and CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes 835 Rule, with a mandated effective date of Jan. 1, 2014.

1. CORE 382 ERA Enrollment Data Rule mandates that health plans are required to offer electronic enrollment for 835/ERA at a minimum and must use standardized templates to collect data for these enrollments.

   If you've already enrolled to receive the electronic 835/ERA, you **do not** have to enroll again. However, if you wish to make an update or cancel your current enrollment or if you are enrolling for the first time, you need to be aware of these changes.

   To complete the new ERA enrollment, log in to the Trading Partner Agreement and Provider Authorization tool using your assigned Provider Trading Partner Agreement ID and password.

   ERA enrollment instructions will display as an option on the *Trading Partner Agreement Provider Menu* screen. If you choose to receive an electronic 835/ERA, complete the appropriate provider authorization to be directed to the 835 Enrollment Form.

2. CORE 360 standardizes the use of adjustment reason and remark codes in the 835/ERA transaction into four different business scenarios:

   - Business Scenario #1: Additional Information Required — Missing/Invalid/Incomplete Documentation
   - Business Scenario #2: Additional Information Required — Missing/Invalid/Incomplete Data from Submitted Claim
   - Business Scenario #3: Billed Service Not Covered by Health Plan
   - Business Scenario #4: Benefit for Billed Service Not Separately Payable

   These changes will allow for a more consistent use of the reason and remark codes by payers for auto-posting of the 835 electronic remittance information. The new listing of codes, organized by business scenario, is available on the CAQH/CORE website at **caqh.org/ORMandate_EFT.php**.

Another operating rule relating to both EFT and 835/ERA

3. CORE 370 EFT and ERA Reassociation (CCD+/835) Rule mandates delivery of an ERA and EFT to be within three business days of each other if you're set up for both.

   Blue Cross Blue Shield of Michigan is required to advise health care providers to notify their financial institution or bank that they have enrolled to use EFT. In addition, providers should request that their financial institution or bank return a health plan payment reassociation number to them in CCD+ format. The reassociation number, located in the addenda record of the banking EFT CCD+ data elements, is necessary for reassociation or tracing of the EFT to ERA in a provider's accounts receivable or practice management system. When addressing this with your financial institution, it's recommended that you speak with the branch manager about obtaining the reassociation number.

Final operating rule relating to EFT only

4. CORE 382 ERA Enrollment Data Rule mandates that health plans are required to offer EFT to all providers and must use standardized templates to collect data for these enrollments.

   BCBSM and BCN require all professional providers to use electronic funds transfer. If you're not, please follow these instructions to begin receiving electronic payments from the Blues:

   - Go to **bcbsm.com/providers.**
   - Click on *Provider Secured Services.*
   - Click on *Online payments and electronic vouchers*.

ERA EFT continued on Page 4

ERA EFT continued from Page 3

All BCBSM PINs associated with the NPIs for which you submit claims must be registered for EFT. EFT offers you faster access to your payments and there's no cost to participate.

BCBSM hospital and facilities have access to online vouchers today but will be able to register for Electronic Funds Transfer beginning Dec. 6, 2013.

To register please follow these steps:

- Log in to Provider Secured Services.
- Scroll down to *Electronic Funds Transfer*, located on the left side of the screen.
- Click on *Register Provider.*
- Complete the information and submit.

Please allow three to five weeks for processing. Once the registration process is complete, all funds for the registered NPI will be sent electronically.

Note for Blue Care Network providers: If you enrolled for EFT directly with BCN, you will need to enroll with BCBSM through Provider Secured Services.

Professional providers or hospitals and facilities that currently do not have access to Provider Secured Services are encouraged to enroll for access as soon as possible. This will ensure that your staff has the access needed on or after Dec. 6, 2013, to register for EFT or be able to view the remittance advice vouchers online when they're no longer provided on paper.

Need help?

- If you need help accessing online remittance advices, signing up for Provider Secured Services or Electronic Funds Transfer, contact your BCBSM provider consultant or BCN provider representative.

  For technical assistance, you also can call the BCBSM Web Support Help Desk at 1-877-258-3932, Monday through Friday from 8 a.m. to 8 p.m.
- For questions or help with 835/ERA, contact the BCBSM EDI Help Desk at 1-800-542-0945, Monday through Friday, from 8 a.m. to 4:30 p.m.

For more information, see the article on Page 2.

Additional preventive medications available at no copayment beginning Jan. 1

Under the Women's Preventive Services mandate of the Affordable Care Act, the Blues currently provide generic oral and injectable prescription contraceptives with no copayment requirement for our female members with commercial pharmacy coverage. Some restrictions apply.*

Beginning Jan. 1, 2014, preventive drug coverage with no member copayment will expand to include additional preventive medications recommended by the U.S. Preventive Services Task Force under the ACA.

Additional preventive drugs that will be covered beginning Jan. 1, 2014, include the following:

Female contraceptives

- Generic and select brand over-the-counter female contraceptive products and select prescription brand contraceptive medications

Other mandated preventive medications

- Aspirin (OTC) — For men ages 45-79 and women ages 55-79 to prevent cardiovascular disease. Generics only.
- Folic acid supplements (OTC) — Females who may become pregnant. Generics only.
- Oral fluoride supplements (prescription) — Children ages 6 months to 5 years without fluoride in their water sources. Generics only.
- Iron supplements (OTC) — Children ages birth to 12 months who are at risk for anemia. Generics only.
- Smoking cessation medications (generic OTC and generic and select brand prescription products) – Members age 18 or older.
- Vitamin D (OTC) — Members age 65 or older who are at increased risk for falls. Generics only.

MEDICATIONS continued on Page 5

MEDICATIONS continued from Page 4

Note: Prescriptions are required for both prescription and OTC products in order for medications to be covered.

Mandated preventive drug coverage with no copay	
Female contraceptives	**Copayment**
Generic oral and injectable prescription contraceptives	Covered in full
Generic and select brand OTC contraceptives (female condom[a], sponge, vaginal film, vaginal foam)	Covered in full[a]
NuvaRing®[b], Ortho Evra Patch®[c]	Covered in full[b,c]
Other mandated preventive drugs	**Copayment**
Generic drugs: OTC and prescription	Covered in full
All generic and select brand smoking cessation drugs (Chantix®[b], Nicotrol®[b], Nicotrol NS®[b])	Covered in full[b]

[a] Male contraceptives (e.g., male condoms) are not covered under the ACA.

[b] BCBSM and BCN members must meet step-therapy criteria to be eligible for no copay. Applies to NuvaRing, Chantix, Nicotrol and Nicotrol NS.

[c] BCN members must meet step-therapy criteria to be eligible for no copay for Ortho Evra Patch.

This information applies to all commercial members, but not to Medicare Advantage members. As always, be sure to check group-specific benefits for complete details.

*Grandfathered groups and retiree opt-out groups are exempt from the mandate. Groups not included in the mandate are BCN Advantage HMO-POS℠ (except BCN Advantage with commercial pharmacy rider), Blue Cross Complete, BCN 65 non-group and MyBlue Medigap℠.

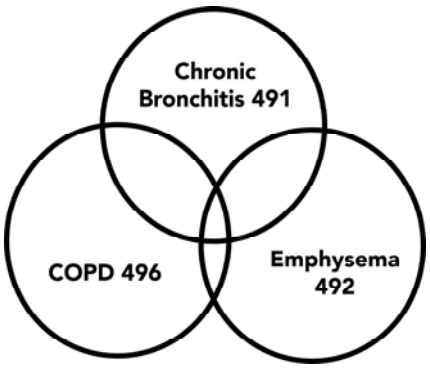
Some group health plans sponsored by certain religious employers are exempt from the requirement to cover contraceptive services. In addition, there are some nonprofit employer groups that were granted a delay on the implementation of this benefit until their first plan year on or after Aug. 1, 2013, based on their religious beliefs.

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.

Keep in mind these coding tips to improve documentation for chronic obstructive pulmonary disease and other associated respiratory conditions

In order to support the ICD-9-CM diagnosis code selected, chronic obstructive pulmonary disease and other associated respiratory conditions need to be properly documented in the medical record.

What's COPD?
Chronic obstructive pulmonary disease is a common and progressive disease that makes it difficult to breathe. Common symptoms include coughing that produces large amounts of mucus, wheezing, shortness of breath and chest tightness. The two main forms of COPD are emphysema and chronic bronchitis. However, many patients with COPD have both emphysema and chronic bronchitis.



What causes COPD?
Smoking cigarettes is the leading cause of COPD. Most people who have COPD are either current smokers or have a history of tobacco use. Other causes include long-term exposure to lung irritants such as air pollution, chemical fumes and dust, all of which can contribute to COPD.

CODING TIPS continued on Page 6

CODING TIPS continued from Page 5

Tips to remember when coding COPD
When coding for COPD, bronchitis (acute, chronic), asthmatic bronchitis (acute, chronic), emphysema and other associated respiratory conditions, it's important to properly code whether or not the condition is acute, chronic or in acute exacerbation.

- Due to the overlapping nature of the conditions that comprise COPD, code selection must be based on terms documented by the provider.
- ICD-9-CM code 496, chronic airway obstruction not elsewhere classified, should only be used if the type of COPD being treated is not specified in the medical record.
- If a provider has documented a patient's status as "status asthmaticus" with any type of COPD or acute bronchitis, the asthmaticus should be sequenced first. (See *ICD-9-CM Official Guidelines for Coding and Reporting*, 8.a.4 and *Coding Clinic*, first quarter 2005, page 50).
- It's imperative to always document and code to the highest specificity. For example, if the provider states "acute bronchitis" or "chronic bronchitis," then report ICD-9-CM codes 466.x and 491.x, respectively. However if the provider does not indicate whether the bronchitis was either acute or chronic, then the appropriate ICD-9-CM code would be 490: *Bronchitis not specified as acute or chronic*.
- When COPD with an acute exacerbation is documented without acute bronchitis, then report ICD-9-CM code 491.21*: Obstructive chronic bronchitis with (acute) exacerbation*.
- Code 491.22 (*Obstructive chronic bronchitis with acute bronchitis)* when the medical record supports acute bronchitis and COPD. In this case, it will be unnecessary to assign code 466.0 (acute bronchitis).

It's important to review the ICD-9-CM Coding Guidelines (Chapter 8: Diseases of Respiratory System 460-519), as well as any instructional notes under the various COPD subcategories and codes in the tabular list of the ICD-9-CM manual, in order to select the correct code.

ICD-9-CM code	Description of respiratory condition
491.0	Simple chronic bronchitis (smoker's cough)
491.1	Mucopurulent chronic bronchitis
491.2x	Obstructive chronic bronchitis *491.20* without exacerbation (emphysema with chronic bronchitis) *491.21* with (acute) exacerbation *491.22* with acute bronchitis
491.8	Other chronic bronchitis
491.9	Unspecified chronic bronchitis
492.8	Emphysema, NOS
493.90	Asthma, unspecified
493.xx	Asthma *493.21* Chronic obstructive asthma with status asthmaticus *493.22* Chronic obstructive asthma with acute exacerbation
496*	Chronic airway obstruction, not elsewhere classified (COPD)
799.02 and 496	Hypoxia and COPD Please note that hypoxia is not an inherent component of COPD (AHA, Coding Clinic, 2009, issue 3).
V44.0	Artificial opening status, tracheostomy
V46.11	Dependence on respirator; ventilator status
V46.14	Complication of respirator; ventilator
V46.2	Supplemental oxygen (long-term oxygen therapy) – Please note that you should code the underlying condition first.
V55.0	Attention to tracheostomy

*This code should not be used with any code from category 491-493.

New *U.P. Blue Referral Form* available for Upper Peninsula Blue℠ members

Blue Cross Blue Shield of Michigan revised the *U.P. Blue Referral Form* for Upper Peninsula Blue members.

It now offers a simple one-page form and a new fax number for submitting the document. You can download and print the *U.P. Blue Referral Form* at **bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/up-blue-referral-form.pdf**.

Please immediately discontinue using the *TRUST PPO/POS Program Referral Form* and the *UP Blue Out-of-State Preauthorization Form*.

Remember to follow these procedures when referring a UP Blue member to an out-of-state provider:

- Complete the referral before the member receives services from an out-of-state provider.
- Complete the *U.P. Blue Referral Form* for applicable UP Hospital Blue members within the tier networks.
- Retrospective referrals will not be approved without documentation from the patient's medical record indicating the referral was initiated prior to the UP Blue member receiving the services.
- Fax the *U.P. Blue Referral Form* and supporting documentation to the Upper Peninsula Health Plan at 906-225-9268. **Note:** This is a **new** fax number.
- The Upper Peninsula Health Plan will notify the referring provider of the decision or need for additional information by fax within 48 hours.
- UPHP will fax the final decision about the referral to the BCBSM Marquette office so that the member can be sent a letter notifying him or her of the decision.
- It is the member's responsibility to monitor and request that his or her claims be reprocessed at his or her plan's designated PPO benefit level if they choose to do so.

There's been a timeline change for requesting retroactive preauthorization for commercial PPO radiology program

Beginning Feb. 1, 2014, PPO providers will have up to 30 days past the date of service to request retro preauthorization through AIM Specialty Health for commercial members participating in our Radiology Management Program. Although 30 days is allowed, we encourage participating providers to obtain authorization **prior to** administering services.

AIM manages utilization for high-technology outpatient diagnostic radiology services offered as part of our Radiology Management Program. AIM was formerly known as American Imaging Management.

Preauthorization requests are initiated through the AIM web-based provider online portal and by phone. In most circumstances, approximately 90 percent of provider authorization cases are completed by AIM within 48 hours of the request. Retro-authorization requests are only accepted by phone, while all other requests can be submitted online or by phone.

To request an AIM authorization, please contact 1-800-72-8008 or visit **AIMSpecialtyhealth.com**.

This change in timeframe brings us into better alignment with other areas of the business and increases efficiency.

For more information about this change, please contact your provider consultant.

Updates to pediatric acute and adult acute criteria become effective Nov. 4, 2013

As of Nov. 4, 2013, updates to the 2013 pediatric acute and adult acute criteria become effective. At that time, you can access the updates by following these steps:

1. Log in to web-DENIS.
2. Click on *BCBSM Provider Publications and Resources.*
3. Click on *Newsletters and Resources.*
4. In the left navigation, click on *Clinical Criteria & Resources.*
5. Scroll down to *BCBSM modifications to Interqual criteria.*
6. Click on *Pediatric Acute Nov 4 2013 Update* or *Adult Acute Nov 4 2013 Update.*

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	
32998 Additional established procedures: **20982, 50542, 50592**	**Basic Benefit and Medical Policy** The safety and effectiveness of radiofrequency ablation of osteoid osteomas have been established. It may be considered a useful therapeutic option when indicated. The safety and effectiveness of radiofrequency ablation to palliate pain in patients with osteolytic bone metastases have been established. It may be considered a useful therapeutic option when indicated. The safety and effectiveness of radiofrequency ablation of renal tumors have been established. It may be considered a useful therapeutic option when indicated. **Continued on next page**

BENEFIT POLICY continued on Page 9

BENEFIT POLICY continued from Page 8

NEW PAYABLE PROCEDURES	
32998 Additional established procedures: **20982, 50542, 50592** ***Continued***	Radiofrequency ablation is an established treatment option in selected patients with primary, non-small cell lung cancer and metastatic pulmonary tumors who are not candidates for surgical intervention, effective May 1, 2013. **Group Variations** Procedure 32998 is not a benefit for Chrysler, Ford, Delphi, URMBT and Federal Employee Program® members. **Inclusionary Guidelines** Radiofrequency ablation is appropriate for osteoid osteomas for those who meet any of the following criteria: • Those who have failed medical therapy • Those being considered for surgical resection • Those who have failed previous surgical therapy and have recurrent symptoms or pain • Additional RF ablation may be appropriate after an initial failed procedure. Radiofrequency ablation is appropriate to palliate pain in patients with osteolytic bone metastases for those who have failed or are poor candidates for standard treatments such as radiation or opioids. Radiofrequency ablation is appropriate to treat localized renal cell carcinoma when **any** of the following criteria are met: • The patient has primary, malignant, Stage IV neoplasm(s) of the kidney no more than 4 cm in size • The patient is unable to tolerate a conventional surgical resection of the neoplasm • In order to preserve kidney function in patients with significantly impaired renal function (e.g., the patient has one kidney or renal insufficiency defined by a glomerular filtration rate of less than 60 mL/min per m2) when the standard surgical approach is likely to substantially worsen existing kidney function. Radiofrequency ablation is appropriate to treat an isolated peripheral non-small cell lung cancer lesion that is no more than 3 cm in size when **all** of the following criteria are met: • Surgical resection or radiation treatment with curative intent is considered appropriate based on stage of disease; however, medical co-morbidity renders the individual unfit for those interventions. **Continued on next page**

BENEFIT POLICY continued on Page 10

BENEFIT POLICY continued from Page 9

NEW PAYABLE PROCEDURES	
32998 Additional established procedures: **20982, 50542, 50592** ***Continued***	• Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery Radiofrequency ablation is appropriate to treat malignant non-pulmonary tumor(s) metastatic to the lung that are no more than 3 cm in size when **all** of the following criteria are met: • In order to preserve lung function when surgical resection or radiation treatment is likely to substantially worsen pulmonary status **or** the patient is not considered a surgical candidate. • There is no evidence of extrapulmonary metastases. • Tumor is located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic arch branches, pulmonary artery and the heart. **Exclusionary Guidelines** • Patients not meeting the patient selection criteria above. • Spinal osteoid osteomas less than one cm from dural or neural structures • Hand lesions, because the small important nerves of the hand cannot be visualized on CT • Osteoid osteomas that can be managed with medical treatment • As initial treatment of painful bony metastases • All indications and tumor types not specifically noted in the Inclusionary section
0318T, 33363-33365, 33367-33369,	**Basic Benefit and Medical Policy** Transcatheter aortic valve replacement performed via any approach with a device approved by the U.S. Food and Drug Administration has been shown to be safe and effective. It is established for patients with severe aortic stenosis who meet the clinical criteria outlined in this policy. The approach used must be determined by the attending physician based on individual clinical, anatomic and prognostic factors. Inclusions have been updated, effective July 1, 2013 **Group Variations** Excludes Chrysler **Continued on next page**

BENEFIT POLICY continued on Page 11

BENEFIT POLICY continued from Page 10

NEW PAYABLE PROCEDURES	
0318T, 33363-33365, 33367-33369, ***Continued***	**Inclusionary Guidelines** Transcatheter aortic valve replacement performed via any approach with a device approved by the U.S. Food and Drug Administration is established for patients with aortic stenosis when **all** of the following conditions are present:** 1. Severe aortic stenosis with a calcified aortic annulus and one or more of the following: • An aortic valve area of less than 0.8 cm^2 • A mean aortic valve gradient greater than 40 mmHg • A jet velocity greater than 4.0 m/sec 2. New York Heart Association heart failure Class II, III or IV symptoms 3. Patient is not a candidate for open surgery, as judged by at least two cardiovascular specialists (cardiologist or cardiac surgeon). **Individuals with annulus diameters measuring greater than 26 mm may be eligible for an Investigational Device Exemption, as the currently FDA-approved devices accommodate annulus diameters measuring 18-26 mm. **Exclusionary Guidelines** • Transcatheter aortic valve implantation using alternate approaches (e.g., transapical or transventricular) The presence of any of the following conditions: • Noncalcified aortic annulus • Congenital unicuspid or congenital bicuspid • Mixed aortic valve disease (aortic stenosis and aortic regurgitation with predominant aortic regurgitation >3+) • Pre-existing or prosthetic heart valve or prosthetic ring in any position • Severe mitral annular calcification, severe (>3+) mitral insufficiency or Gorelin syndrome • Blood dyscrasias defined as: leukopenia (WBC<3000 mm^3), acute anemia (Hgb <9 mg%), thrombocytopenia (platelet count <50,000 cells/mm^3, or history of bleeding diathesis or coagulopathy • Hypertrophic cardiomyopathy with or without obstruction • Left ventricular ejection fraction ≤ 20% • Active bacterial endocarditis within 6 months (180 days) of procedure **Continued on next page**

BENEFIT POLICY continued on Page 12

BENEFIT POLICY continued from Page 11

NEW PAYABLE PROCEDURES	
0318T, 33363-33365, 33367-33369, ***Continued***	• Echocardiographic evidence of intracardiac mass, thrombus or vegetations, or other active infections • A known hypersensitivity or contraindication to aspirin, heparin, ticlopidine (Ticlid), or clopidogrel (Plavix), or sensitivity to contrast media, which cannot be adequately premedicated • Native aortic annulus diameter of < 18mm or > 25mm as measured by echocardiogram • Abdominal aortic or thoracic aneurysm (defined as maximal luminal diameter 5 cm or greater) • Significant aortic disease, including abdominal aortic or thoracic aneurysm defined as maximal luminal diameter 5 cm or greater, marked tortuosity (hyperacute bend), aortic arch atheroma (especially if thick [> 5 mm], protruding or ulcerated) or narrowing (especially with calcification and surface irregularities) of the abdominal or thoracic aorta, severe "unfolding" and tortuosity of the thoracic aorta • Ililiofemoral vessel characteristics that would preclude safe placement of 22F or 24F introducer sheath such as severe obstructive calcification, severe tortuosity or vessels size less than 7 mm in diameter and bulky calcified aortic valve leaflets in close proximity to coronary ostia (applicable for transfemoral introduction) • Evidence of an acute myocardial infarction ≤ 1 month (30 days) before the intended treatment; substantial coronary artery disease requiring revascularization • Any therapeutic invasive cardiac procedure resulting in a permanent implant that is performed within 30 days of the index procedure (e.g., PCI). Implantation of a permanent pacemaker is not excluded. • Active upper GI bleeding within three months (90 days) prior to procedure • Clinically (by neurologist) or neuroimaging-confirmed stroke or transient ischemic attack within 6 months (180 days) of the procedure • Renal insufficiency (creatinine> 3.0 mg/dL) or renal replacement therapy at the time of screening • Estimated life expectancy < 24 months (730 days) due to carcinomas, chronic liver disease, chronic renal disease or chronic end stage pulmonary disease. • The individual was offered surgery but refused.
43289	**Basic Benefit and Medical Policy** Magnetic esophageal ring insertion for the treatment of gastroesophageal reflux is considered experimental. The use of this device has not been scientifically shown to improve patient clinical outcomes. This policy is effective Nov. 1, 2013.

BENEFIT POLICY continued on Page 13

BENEFIT POLICY continued from Page 12

NEW PAYABLE PROCEDURES	
81235, 81252-81254, 81321-81326, 81506, 81508, 81510, 81512, G0452	**Group Variations** Listed procedure codes are payable for Federal Employee Program® members, effective Jan. 1, 2013.
90644	**Group Variations** Payable for Federal Employee Program members only, effective July 1, 2012
99441-99443	**Group Variations** Payable for Federal Employee Program members, effective July 1, 2013
A9586	**Group Variations** Effective Jan. 1, 2013, procedure code A9586 is payable for Federal Employee Program members.
J7665	**Basic Benefit and Medical Policy** The safety and effectiveness of inhaled dry powder mannitol in the diagnosis and management have been established. It may be considered a useful diagnostic option when indicated, effective July 1, 2012. **Group Variations** • Not covered for MPSERS, Chrysler and URMBT members. • Payable for GM hourly and salaried members, effective Nov. 1, 2012. • Payable for Ford hourly and salaried members, effective Jan. 1, 2013. **Inclusionary Guidelines** • As an aid in the diagnosis of asthma • To assess response to steroid therapy • To guide steroid reduction **Exclusionary Guidelines** • Children under age 6
Q0507-Q0509	**Group Variations** Effective April 1, 2013, procedure codes Q0507, Q0508 and Q0509 are payable for the Federal Employee Program.
Q4131-Q4136	**Group Variations** Payable for Federal Employee Program members, effective Jan. 1, 2013
UPDATES TO PAYABLE PROCEDURES	
0184T	**Basic Benefit and Medical Policy** The safety and effectiveness of transanal endoscopic microsurgery have been established. It may be considered a useful therapeutic procedure for patients meeting patient selection criteria. **Group Variations** Payable for Chrysler hourly and salaried members, effective Jan. 1, 2012

BENEFIT POLICY continued on Page 14

BENEFIT POLICY continued from Page 13

UPDATES TO PAYABLE PROCEDURES	
0308T	**Basic Benefit and Medical Policy** The safety and effectiveness of the implantable miniature telescope for the treatment of end stage, age-related wet macular degeneration have been established. It is a useful therapeutic option for patients meeting specified criteria. **Group Variations** Payable for URMBT members, effective Dec. 1, 2012
33361, 33362	**Basic Benefit and Medical Policy** Transcatheter aortic valve replacement performed via the transfemoral approach with a device approved by the U.S. Food and Drug Administration is established for patients with aortic stenosis who meet medical policy guidelines. **Group Variations** Payable for Ford hourly and salaried members, effective Jan. 1, 2013
47370	**Group Variations** Procedure code 47370 is now payable for MPSERS for professional claims. Facility claims are already payable.
59400	**Payment Policy** Payable to certified nurse midwife for groups with global maternity coverage.
76390	**Basic Benefit and Medical Policy** The safety and effectiveness of magnetic resonance spectroscopy have been established for patients meeting specific patient selection criteria. Inclusionary guidelines were updated, effective May 1, 2013. **Payment Policy** May be subject to the PPO Radiology Management Program guidelines. **Inclusionary Guidelines** MRS is an appropriate clinical tool for diagnosing: • Disorders of creatine metabolism • Presence of mitochondrial disease. • MRS may be used to assist in distinguishing tissue necrosis from persistent or recurrent brain tumor as an alternative to invasive brain biopsy. **Exclusionary Guidelines** MRS for any other condition than listed in the inclusions.
76514	**Basic Benefit and Medical Policy** Procedure code 76514 has been removed from the Radiology Management Privileging Program, effective March 1, 2013.

BENEFIT POLICY continued on Page 15

BENEFIT POLICY continued from Page 14

UPDATES TO PAYABLE PROCEDURES	
78015, 78016, 78018, 78020, 78070, 78075, 78099, 78102-78104, 78110, 78111, 78120-78122, 78130, 78135, 78140, 78185, 78190, 78191, 78195, 78199, 78201, 78202, 78205, 78206, 78215, 78216, 78226, 78227, 78230-78232, 78258, 78261, 78262, 78264, 78267, 78268, 78270-78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 78445, 78451-78454, 78456-78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78496, 78499, 78579, 78580, 78582, 78597-78601, 78605-78607, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78699-78701, 78707-78710, 78725, 78730, 78740, 78761, 78799	**Payment Policy** Effective Jan. 1, 2011, the listed procedure codes are payable to providers with a specialty of nuclear medicine under the PPO Radiology Management Program. **Group Variations** The Federal Employee Program is excluded from the Radiology Management Program.
81500, 81503 (effective Jan. 1, 2013) **84999 (effective Sept. 1, 2012)**	**Basic Benefit and Medical Policy** The safety and effectiveness of proteomics-based testing for the evaluation of ovarian (adnexal) masses (e.g., OVA1 and ROMA tests) have been established. It may be considered a useful diagnostic option for women meeting the patient selection criteria. **Group Variations** Evaluation of ovarian (adnexal) masses by Proteomics-based testing (e.g., OVA1® and ROMA™) is payable for GM hourly and salaried employees, effective Sept. 1, 2012. **Inclusionary Guidelines** Testing of patients with ovarian (adnexal) mass(es), when the physician's (other than gynecologic oncologist) independent clinical and radiological preoperative evaluations do not indicate malignancy. Patients should meet the following criteria: • Women older than 18 years • Surgical treatment of the mass is already planned. • The woman has not yet been referred to a gynecologic oncologist. **Exclusionary Guidelines** All other uses proteomics-based testing for ovarian masses are considered experimental including, but not limited to: • Screening for ovarian cancer • Selecting patients for surgery for an adnexal mass • Evaluation of patients with clinical or radiologic evidence of malignancy • Evaluation of patients with nonspecific signs or symptoms suggesting possible malignancy • Postoperative testing and monitoring to assess surgical outcome or to detect recurrent malignant disease following treatment.

BENEFIT POLICY continued on Page 16

BENEFIT POLICY continued from Page 15

UPDATES TO PAYABLE PROCEDURES	
E0621, E0625, E0630, E0635, E0636, E0639, E0640, E1035, E1036	**Inclusionary Guidelines** A patient lift is covered if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the patient would be bed confined. A patient lift described by procedure codes E0630 or E0635, E0639 or E0640 is covered if the basic coverage criteria are met. If the coverage criteria are not met, the lift will be denied as not reasonable and necessary. **Procedure code E0625 is currently not payable.** A multi-positional patient support/transfer system (E0636, E1035, E1036) is covered if both of the following criteria are met: 1. The basic coverage criteria for a lift are met. 2. The patient requires supine positioning for transfers. If either criterion 1 or 2 is not met, codes E0636, E1035 and E1036 will be denied as not reasonable and necessary. If coverage is provided for code E1035 or E1036, payment will be discontinued for any other mobility assistive equipment, including but not limited to: canes, crutches, walkers, roll about chairs, transfer chairs, manual wheelchairs, power-operated vehicles or power wheelchairs. Code E0621 is covered as an accessory when ordered as a replacement for a covered patient lift. Modifier KX is the appropriate modifier for the patient lifts procedures. The effective date is March 1, 2013. **Group Variations** Includes Delphi hourly and salaried, Chrysler nonbargaining consumer-directed health plan with a health savings account (group number 82100) only, GM and URMBT members when BCBSM has claim processing responsibility (POS 3 and others except POS 4). Excludes Ford hourly and salaried, Chrysler bargaining and nonbargaining (except group number 82100), GM and URMBT members when vendor (NNPN/HMENN) has claim processing responsibility (POS 4). This change does not apply to groups that have DME carved out to a vendor.

BENEFIT POLICY continued on Page 17

BENEFIT POLICY continued from Page 16

UPDATES TO PAYABLE PROCEDURES	
L1830, L1832, L1834, L1843-L1846	**Inclusionary Guidelines** Covered for non-traumatic rupture of patellar tendon. This diagnosis is payable in addition to conditions already payable.
POLICY CLARIFICATIONS	
0207T, 0330T	**Basic Benefit and Medical Policy** Eyelid thermal pulsation for the treatment of dry eye syndrome and interferometric color assessment of the tear film by specular reflection is considered experimental. They have not been scientifically demonstrated to improve patient clinical outcomes. This policy update is effective Nov. 1, 2013.
20245, 21556, 38510, 48100, 88311, 88312, 88346, 92520, 97027, 97535, 97750, 99284, D7210, E0486	**Basic Benefit and Medical Policy** Procedure codes are either payable or non-payable to D.D.S. and oral surgeon specialties as identified. **Non-payable procedures to D.D.S. and oral surgeon** 20245, 21556, 48100, 92520, 97027, 97535, 97750, 99284 **Payable procedures to D.D.S., but not an oral surgeon** 88311, 88312, 88346 **Payable procedure to oral surgeon, but not a D.D.S.** 38510 **Payable procedures to both D.D.S. and oral surgeon** D7210, E0486
38999, S2140, S2142, S2150	**Basic Benefit and Medical Policy** The inclusionary and exclusionary criteria for the Placental and Umbilical Cord Blood as a Source of Stem Cells Policy have been updated, effective Nov. 1, 2013. **Inclusionary Guidelines** • Transplantation of cord blood stem cells from related or unrelated donors may be considered established in patients with an appropriate indication for allogeneic stem-cell transplant** • Collection and storage of cord blood from a neonate may be considered established when an allogeneic transplant is imminent in an identified recipient with a diagnosis that is consistent with the possible need for allogeneic transplant** ****Refer to specific bone marrow transplant policies to determine if the transplant is covered for a specific diagnosis.** **Continued on next page**

BENEFIT POLICY continued on Page 18

BENEFIT POLICY continued from Page 17

POLICY CLARIFICATIONS	
38999, S2140, S2142, S2150 ***Continued***	**Exclusionary Guidelines** • Prophylactic collection and storage of cord blood from a neonate is considered experimental when proposed for some unspecified future use as an autologous stem-cell transplant in the original donor, or for some unspecified future use as an allogeneic stem-cell transplant in a related or unrelated donor. • Transplantation of cord blood stem cells from related or unrelated donors is considered experimental in all other situations.
64633-64636, 64999	**Basic Benefit and Medical Policy** The inclusionary and exclusionary guidelines for the Facet Joint Denervation Policy have been updated, effective Nov. 1, 2013. **Inclusionary Guidelines** Candidates for radiofrequency facet denervation must meet **all** of the following criteria: • No prior spinal fusion surgery in the vertebral level being treated. • Disabling low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations, and the pain is not radicular. • Pain has failed to respond to three months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy and a home exercise program. • There has been a successful trial of controlled medial branch blocks.** • If there has been a prior successful radiofrequency denervation, there should be a minimum time of six months since the prior RF treatment (per side, per anatomical level of the spine). **A successful trial of controlled diagnostic medial branch blocks consists of two separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in at least a 50 percent reduction in pain for the duration of the local anesthetic used (e.g., three hours longer with bupivacaine than lidocaine). No therapeutic intra-articular injections (e.g., steroids, saline or other substances) should be administered for a period of at least four weeks prior to the diagnostic medial branch block. **Continued on next page**

BENEFIT POLICY continued on Page 19

BENEFIT POLICY continued from Page 18

POLICY CLARIFICATIONS	
64633-64636, 64999 ***Continued***	The diagnostic blocks should involve the levels being considered for RF treatment and should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure). These diagnostic blocks should be targeted to the likely pain generator. Single level blocks lead to more precise diagnostic information, but multiple single level blocks require several visits and additional exposure to radiation. **Exclusionary Guidelines** • Radiofrequency denervation is considered experimental for the treatment of chronic spinal or back pain for all uses that do not meet the criteria listed above, including, but not limited to, treatment of thoracic or sacroiliac facet joint pain. • All other methods of denervation are considered experimental for the treatment of chronic spinalor back pain, including, but not limited to, pulsed radiofrequency denervation, laser denervation, chemodenervation, water-cooled radiofrequency denervation and cryodenervation. • Therapeutic medial branch blocks • If there has been a prior successful radiofrequency denervation, additional diagnostic medial branch blocks for the same level of the spine are not medically necessary. **Note:** In June 2005, the American Medical Association's CPT Editorial Panel determined that the unlisted CPT code 64999 should be used for **pulsed** RF treatment as opposed to other specific codes.
92227, 92228	**Basic Benefit and Medical Policy** The criteria for Diabetic Retinal Telescreening have been updated, effective Nov. 1, 2013. **Inclusionary Guidelines** • The imaging technique covers a total retinal area, which includes the Diabetic Retinopathy Study seven-standard fields (DRS7) **and** • The retinal images are graded for diabetic retinopathy using either a manual or automated process **Exclusionary Guidelines** • To screen or evaluate retinal conditions other than diabetic retinopathy, including, but not limited to, macular degeneration • When the final composite image captured does not include the entire DRS7 field area

BENEFIT POLICY continued on Page 20

BENEFIT POLICY continued from Page 19

POLICY CLARIFICATIONS	
92499, S0515, V2531, V2627	**Basic Benefit and Medical Policy** The criteria for the Corneal Liquid Bandage Lens for Corneal Epithelial Defects/Scleral Senses Policy have been updated, effective Nov. 1, 2013. **Guidelines** **Note:** Measuring and fitting of these therapeutic lenses may take several sessions at the provider's office. The patient may have to undergo a number of fittings using trial lenses until the best match for the patient's needs is found. The choice of gas-permeable versus soft contact lenses is dependent on the patient's disease process and physician determination of the appropriate therapy. **Inclusionary Guidelines** Rigid gas-permeable scleral contact lenses as corneal liquid bandages are considered established for patients who meet **both** of the following criteria: • The individual has persistent epithelial defects of the cornea with documented, disabling symptoms (e.g., pain, photophobia) that have not responded to medical intervention, including topical medications or standard spectacle or contact lens fitting. • The individual has any of the following conditions for which surgery is undesirable or contraindicated. **Note:** This list may not be all-inclusive: o Corneal stem cell deficiencies: – Stevens-Johnson disease (a syndrome of systemic, as well as more severe, mucocutaneous lesions that results in corneal opacities, perforations or blindness) – TEN (toxic epidermal neurolysis) – Conditions that result from a chemical or traumatic injury ▪ Previous surgery ▪ Acquired aniridia ▪ Recurrent corneal erosion ▪ Postsurgical eyelid defect(s) ▪ Exposure keratitis ▪ Lacrimal or meibomian gland obliteration ▪ Superior limbal keratoconjunctivitis ▪ Inflammatory corneal degeneration ▪ Keratoconus ▪ PED resulting from superior limbic keratotomy

BENEFIT POLICY continued on Page 21

BENEFIT POLICY continued from Page 20

POLICY CLARIFICATIONS

92499, S0515, V2531, V2627

Continued

- Neurotrophic (anesthetic) corneas
  - From acquired causes, including, but not limited to:
    - Corneal denervation that is related to acoustic neuroma surgery
    - Trigeminal ganglionectomy
    - Herpes simplex or zoster of the cornea
    - Complications of diabetes
    - Idiopathic corneal stem cell deficiency
  - From congenital causes, including, but not limited to:
    - Seckle's syndrome
    - Congenital corneal anesthesia
    - Congenital eyelid defect(s)
    - Congenital dysautonomia (e.g., Riley-Day Syndrome)
- Severe dry eyes (keratoconjunctivitis sicca) due to
  - Sjögren syndrome
  - Graft vs. host disease
  - Post-radiation treatment
  - Eye surgery
  - Severe meibomian gland deficiency
- Corneal disorders associated with:
  - Systemic autoimmune diseases
    - Rheumatoid arthritis
    - Dermatological disorders such as atopic, epidermolysis bullosa, epidermal dysplasia)

The use of therapeutic **soft** contact lenses as corneal liquid bandages is considered established for patients who meet **both** of the following criteria:

- The individual has persistent epithelial defects of the cornea with documented, disabling symptoms (e.g., pain, photophobia) that have not responded to medical intervention, including topical medications or standard spectacle or contact lens fitting.
- The PED is associated with any of the following conditions (this list may not be all-inclusive):
  - Bullous keratopathy
  - Permanent keratoprosthesis
  - Filamentary keratitis
  - PEDs resulting from penetrating keratoplasty

Continued on next page

BENEFIT POLICY continued on Page 22

BENEFIT POLICY continued from Page 21

GROUP BENEFIT CHANGES	
92499, S0515, V2531, V2627 ***Continued***	– Following the use of cyanoacrylate (tissue) glue to provide protection to an adhesive plug over a corneal wound – Severe dry eyes (due to conditions such as Stevens-Johnson syndrome, radiation, graft vs host disease, meibomian gland deficiency, etc.) – Corneal disorders associated with systemic autoimmune diseases – Corneal exposure (e.g., anatomic, paralytic). – Neurotrophic (anesthetic) corneas
NONPAYABLE PROCEDURES	
A6250, A9155	**Basic Benefit and Medical Policy** Effective March 1, 2013, procedure codes A6250 and A9155 are no longer payable and will reject as not a benefit for all groups. We are making this change to align with Center for Medicare & Medicaid policy for these procedure codes, which are not payable under Medicare.
EXPERIMENTAL PROCEDURES	
0329T	**Basic Benefit and Medical Policy** The use of continuous intraocular pressure monitoring devices is considered experimental. There is insufficient evidence to permit conclusions on health outcomes and there is not FDA approval for 24-hour continuous intraocular pressure monitoring for glaucoma. This policy is effective Nov. 1, 2013.
81324-81326	**Basic Benefit and Medical Policy** Genetic testing to confirm a diagnosis of an inherited peripheral neuropathy is considered experimental. The diagnosis of an inherited peripheral neuropathy is generally made based on clinical assessment and as there is no specific therapy the benefit of a genetic confirmation of these disorders is not known. This policy is effective Nov. 1, 2013.
81479	**Basic Benefit and Medical Policy** Genetic cancer susceptibility panels using next generation sequencing are considered experimental. There is insufficient analytical and clinical validity to support the clinical utility of this testing in improving patient's clinical outcomes. This policy is effective Nov. 1, 2013.
GROUP BENEFIT CHANGES	
Aramark Corporation	Aramark Corporation, group number 007039190 has joined BCBSM, effective Oct. 1, 2013. The group offers medical-surgical coverage, one prescription drug plan, one dental plan and one VSP vision plan. Member ID cards will show alpha prefix ITF.

BENEFIT POLICY continued on Page 23

BENEFIT POLICY continued from Page 22

GROUP BENEFIT CHANGES	
Federal Screw Works	Effective Nov. 1, 2013, Medicare-eligible retirees of the Federal Screw Works 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 26418 with suffixes 601, 602 and 603. 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.**
Kalitta Companies	Kalitta Companies, group number 71576, has joined BCBSM, effective Oct. 1, 2013. The group offers two PPO plans with medical-surgical coverage, two prescription drug plans, one dental plan, one vision plan, one hearing plan and one consumer-directed health plan with a health savings account. Member ID cards will show alpha prefix KAD.
UP Plumbers and Pipefitters	Effective Nov. 1, 2013, Medicare-eligible retirees of the UP Plumber and Pipefitters 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 60391 with suffix 600. You can identify members by the XYL prefix on their ID cards, like those of other Medicare Plus Blue Group PPO plans. For information about our Medicare Advantage PPO plan, go to **bcbsm.com/provider/ma.**

BCBSM prepares for new CMS-1500 claim form

When we reported in a web-DENIS message in July that the National Uniform Claim Committee had approved a new version of the CMS-1500 Health Insurance Claim Form, we didn't have the transition timeline available to share with you. This article provides additional details about the transition to the new form.

Blue Cross Blue Shield of Michigan will begin accepting the revised CMS-1500 claim form (version 02/12) **on Jan. 6, 2014**. It will replace the current form (version 08/05) as well as the Michigan Status Claim Review Form.

The 1500 claim form is a paper claim form used by professional health care providers, while the Michigan Status Claim Review Form is used if a claim is rejected or if payment received is different from what was anticipated. The new claim form (version 02/12) can be used for both purposes.

You can continue to use the old paper CMS-1500 claims through March 31, 2014. See timeline below.

Approximately 18 fields have changed on the new form. Most include changes to the names on certain boxes, instructions for completing the information in specific boxes or the number of spaces allotted for diagnosis codes.

To help you prepare to use the new version of the paper claim form, we will include line-by-line instructions for completing it in the *Claims* chapter of our online provider manual beginning Dec. 1, 2013. (The *Claims* chapter of the manual will include two sets of instructions for completing CMS-1500 claims — one for each version — until April 1, 2014.)

You'll be able to order the new form (version 02/12) after Jan. 1, 2014, by using the Blue Pages Directory on web-DENIS. We'll provide additional details in the January *Record.*

For more information, contact your provider consultant or visit **NUCC.org**. The site includes instructions for completing the form.

See draft of new form at right.

Before Jan. 6, 2014	Jan. 6, 2014, through March 31, 2014 (dual acceptance period)	As of April 1, 2014
Professional providers who don't submit claims electronically should use the 08/05 version of the CMS-1500 claim form and the Michigan Status Claim Review Form.	Providers can submit either the 08/05 version or the Michigan Status Claim Review Form, or the 02/12 version of the new CMS-1500 claim form.	Providers should only submit the 02/12 version of the CMS-1500 claim form. The Michigan Status Claim Review Form is discontinued.

BCBSM wants to hear from office staff in 2013 satisfaction survey

Blue Cross Blue Shield of Michigan is requesting feedback from physician office and billing managers through the 2013 Physician Office Staff Satisfaction Survey.

The survey was mailed in October to participating M.D. and D.O. offices and can be returned by mail or completed online. It includes questions about claims processing, patient information systems and your experiences with BCBSM representatives.

We're committed to improving our relationship with physician offices. The survey is one way for us to assess our progress and identify opportunities for providing you with better service.

An independent research firm is collecting and tabulating results from the survey on our behalf. The information you provide is confidential, and your responses will be combined with those from other physician offices.

We appreciate the feedback we've received in past years and hope to hear from you again this year.

DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

OMB APPROVAL PENDING

Some Physician Group Incentive Program specialty practices eligible for fee uplifts in 2014

Specialty practices that participate in the Physician Group Incentive Program may be eligible for fee uplifts for services performed from Feb. 1, 2014, to Jan. 31, 2015. Specific criteria apply, and practices must be nominated by a PGIP physician organization by Nov. 12, 2013.

PGIP member practices in the following specialty areas will be considered for the fee uplifts:

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

To receive the uplift, the following criteria apply:

- Practitioners in a practice **must be** a member of a physician organization participating in PGIP as of Aug. 1, 2013.
- At least one PGIP physician organization (or two in some cases) **must nominate** each specialty practice.
- Once nominated, specialist practices must meet performance metric rankings developed by Blue Cross Blue Shield of Michigan.

PGIP POs can nominate specialist practices that:

- Include at least one practitioner from one or more of the 24 eligible specialties
- Have signed a Primary Care-Specialist Agreement with their PO
- Have displayed a high level of engagement with the PO
- Are actively involved in managing and optimizing the use of services and quality of care
- Are partnering with primary care physicians to improve care processes and coordination

PGIP physician organizations must submit nominations via the PGIP Collaboration SharePoint site by Nov. 12, 2013. Information about the nomination process was provided to the physician organizations through webinars and related documents.

Fee uplift available to doctors recognized in Hospital Collaborative Quality Initiatives

The seven hospital-based Collaborative Quality Initiatives listed below have been selected to participate in our CQI physician recognition reward program. The CQI physician recognition program rewards participating site physician champions and physician leaders that are highly engaged in CQI activities.

Each coordinating center develops a "physician index" specific to its CQI that consists of measures aimed at evaluating active participation. Each CQI nominates engaged physician champions and physician leaders who meet or exceed a threshold on the physician index. The nominated physicians will be eligible for 2 percent fee uplifts for the same procedure and clinical service codes used for the PGIP specialist fee uplifts. The recognition uplift will apply to fees from Feb. 1, 2014, through Jan. 31, 2015.

Physicians may receive these recognition payments in addition to any PGIP performance-based fee uplifts as described in the article at left. As background, in 2013, we applied the CQI recognition uplift to a limited number of evaluation and management service codes. In 2014, we will apply the CQI recognition uplift to most procedure codes, except those for ambulance service, durable medical equipment, prosthetics and orthotics, anesthesia, immunizations, hearing, vision, lab, dental and most injections.

The following CQIs are taking part in the recognition reward distribution for 2014:

- Blue Cross Blue Shield of Michigan Cardiovascular Consortium — Percutaneous Coronary Interventions
- Blue Cross Blue Shield of Michigan Cardiovascular Consortium —– Vascular Interventions Collaborative
- Michigan Surgical Quality Collaborative
- Michigan Bariatric Surgery Collaborative
- Michigan Trauma Quality Improvement Program
- Michigan Anticoagulation Quality Improvement Initiative
- Hospital Medicine Safety Consortium

For more information, please contact our CQI administrative team at CQIPrograms@bcbsm.com.

PGIP FEE continued on Page 27

PGIP FEE continued from Page 26

Nomination by a PO does not guarantee that a practice will be selected for a fee uplift. The selected practices will receive a fee uplift for one year — from Feb. 1, 2014, through Jan. 31, 2015. The nomination and selection process will be repeated annually.

Blue Cross will rank practices using population-based metrics. The top third of nominated adult specialty practices and nominated neonatal care practices will receive a 10 percent fee uplift, and the middle third will receive a 5 percent fee uplift. Nominated pediatric specialty practices will receive a 10 percent uplift.

In 2013, we applied the specialist fee uplifts to a limited number of evaluation and management service codes. In 2014, we will apply the specialist fee uplifts to most procedure codes, except those for ambulance service, durable medical equipment, prosthetics and orthotics, anesthesia, immunizations, hearing, vision, lab, dental and most injections.

Oncologists who are not selected for performance-based fee uplifts are eligible for a 5 percent fee uplift if they do one of the following:

- Participate in both the Michigan Oncology Clinical Treatment Pathways Program and the Michigan Oncology Quality Collaborative.
- Achieve certification through the Quality Oncology Practice Initiative.

For more information, contact your provider consultant.

National drug code processing for specialty drug claims delayed until Nov. 15

BCBSM will delay the move to processing certain health care providers' specialty drug claims at the national drug code level.

We told you in September that we would begin this transition Oct. 15 for limited distribution drug specialty pharmacy network providers and for Walgreens' Specialty Pharmacy. Instead, we will begin processing these claims at the national drug code level beginning Nov. 15.

See the September issue of *The Record* for details about the transition.

The change is part of an initiative to process all medical drug claims — those specialty drugs administered by a health care practitioner — at the national drug code level. Look for more information in future issues of *The Record*.

Advanced Cardiac Imaging Consortium closing in February 2014

As of Feb, 1, 2014, we will retire the Advanced Cardiac Imaging Consortium, sponsored by Blue Cross Blue Shield of Michigan and Blue Care Network.

Over the last seven years, the ACIC collaborative quality initiative has made a significant impact on the cardiac imaging community. At the state, regional and national levels, it has stimulated radiation dose reduction and appropriate use of coronary CT angiography.

We take tremendous pride in the accomplishments of the collaborative. Each participating facility is to be commended for their contribution towards reaching the goals of the ACIC. Among their accomplishments:

- The demonstration of a 77 percent reduction in radiation dose associated with CCTA over the past seven years
- A 60 percent decrease in inappropriate use of CCTA

ACIC PROGRAM continued on Page 28

PROFESSIONAL, FACILITY

ACIC PROGRAM continued from Page 27

Transition to closure
During the coming months, the Blues and the ACIC Coordinating Center will be winding down their activities. **Through Jan. 31, 2014, CCTA procedures will continue to be reimbursed at current ACIC CQI participating facilities.**

Effective Feb.1, 2014, the requirement to participate in the ACIC will be eliminated. Keep the following requirements in mind:

- CCTA procedures performed in outpatient settings (excluding the emergency room) will require an approved prior authorization for reimbursement. Blue Cross and BCN use the same prior authorization criteria for these services. For Blue Cross members, visit **aimspecialtyhealth.com** or call 1-800-728-8008.
- For BCN members, providers may submit requests for clinical review for CCTA procedures to BCN electronically. Users will be prompted to complete an appropriateness questionnaire for clinical review consideration. If the criteria are met, the request will be automatically approved. If the criteria are not met, the request will require further clinical review. Health care providers may also contact BCN's Care Management department at 1-800-392-2512 to request clinical review.

These requirements impact procedure codes *75572 through *75574.

If you have any questions, contact your provider consultant.

FACILITY

Blues asking hospital administrators for feedback

Blue Cross Blue Shield of Michigan is conducting its 2013 satisfaction survey of hospital administrators this month.

Called the 2013 BCBSM Hospital Patient Account Manager Satisfaction Survey, the survey was sent in October to patient account managers or billing directors at hospitals. One account manager from each acute care participating hospital was invited via email to complete the online survey, which asks about their experiences with BCBSM representatives, claims processing and patient information systems.

We'll use the data that we collect from this survey, combined with feedback from past surveys, to help develop initiatives to improve our daily interactions with facilities. The results will allow us to assess our performance and identify specific areas where we need to make improvements.

Your feedback is very important to us, so please take the time to respond.

An independent research firm is conducting the survey and tabulating the results, which will be an aggregate of all responses.

Changes to hospital outpatient surgical procedures reimbursement policy explained

Benefits for outpatient facility services that need a Current Procedural Terminology or Health Care Procedure Coding System procedure code are based only on the reported procedure code, and not the related revenue code.

Keep the following in mind:

- When a surgical procedure code can't be paid based on the group's benefits, it will be rejected, which may affect a provider's reimbursement.

SURGERY continued on Page 29

SURGERY continued from Page 28

- When two or more surgical procedures are performed and only one of the procedures is a member benefit. BCBSM will pay for that procedure, which is covered based on the approved amount.

Currently, there are no changes to how multiple surgical procedures are reported, or when two or more surgical procedures are performed during the same visit and two or more of the procedures are payable benefits. BCBSM will continue to reimburse facilities at 125 percent of the payable highest-fee procedure.

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

CCPS now processes credentialing for all Blues hospital, non-hospital facilities

The Corporate Credentialing and Program Support department now manages the credentialing process for all hospital and non-hospital facilities applying to join the Blues' network. This change, which took effect July 1, 2013, includes all managed care and Traditional networks.

The minimum credentialing requirements include:

- Completed and signed credentialing and recredentialing application
- Medical director (an M.D., D.O. or physical therapist for occupational physical therapy) with a valid state license and in good standing
- Valid facility state license
- Valid pharmacy license (for ambulatory infusion centers)
- Both general and professional liability malpractice insurance
- Accreditation or a current Centers for Medicare & Medicaid Services survey

Failure to meet these requirements could result in affiliation denial or termination from all networks.

For questions about re-credentialing only, please email profcredentialing@bcbsm.com.

Pulmonary rehabilitation services will no longer need Case Management review

The Case Management unit will no longer manually process initial or extension requests for pulmonary rehabilitation services, effective with dates of service after Jan. 1, 2014.

Providers should bill electronically for pulmonary rehabilitation services as a facility claim, using revenue code 0948 (pulmonary rehab).

In addition, pre-authorized, individual treatment plans or agreement-to-pay letters won't be needed to make a payment.

Please contact your provider consultant if you have questions about these changes.

Here's how to verify benefits for outpatient facility services

Benefits for outpatient facility services that need a Current Procedural Terminology or Health Care Procedure Coding System procedure code are based only on the reported procedure code, and not the related revenue code.

Please remember that when a procedure code can't be paid based on the group's benefits, the payment will be rejected and become the member's responsibility.

VERIFY BENEFITS continued on Page 30

FACILITY

VERIFY BENEFITS continued from Page 29

To check a member's benefits, based on the HCPCS code, for Michigan Operating Systems migrated groups:

- Log in to web-DENIS.
- Click on *Subscriber Info.*
- Click on *Benefit Search.*
- Click on the *Benefit Package Report* tab.
- Enter the *Benefit Package* information.
- Enter the HCPCS code under *Topic* and click on *Finish.*
- Click on *Search.*

The results are displayed in the *Benefit Package Report* tab under *Coverage Status*, and are not a guarantee of payment.

Member benefits for non-migrated National Accounts Service Company groups are available only on web-DENIS, and are based on the benefit category. To check a member's benefits:

- Log in to web-DENIS
- Click on *Subscriber Info*
- Click on *Eligibility/Coverage/Coordination Of Benefits*
- Enter the contract number
- Click on *Enter*
- Under Current Coverage Member Information, click on *Detailed Benefits,* then on *HOSP*
- Click on *Hospital Outpatient* provider type and click on *Go.*
- Review benefits.

Facility payment rules will still be available under the *HCPCS Payment Rule Display* tab under *Facility Claims* on web-DENIS. If you have any questions about how to view this information, please contact your provider consultant.

Clarification: Healthcare Common Procedure Coding System codes updated for revenue code chart

An article that appeared in the September *Record* should have included revenue code 0750 in the "Other" section of the revenue code table. In the article, we mentioned that revenue code 0750 was added to the "Other" category but did not include the code in the table.

Please reference the online version of the September *Record* article titled "Healthcare Common Procedure Coding System codes updated for revenue code chart" to see the full story with the corrected code table. Go to **bcbsm.com/providers**, click on the *Newsletters* tab, and then click on *The Record Archive*.

PHARMACY

New Custom Select Drug List available Jan. 1

Blue Cross Blue Shield of Michigan and Blue Care Network have developed a new Custom Select Drug List that will be used for all BCBSM and BCN small group and individual members in 2014. This new Custom Select Drug List is roughly based on our Custom Drug List (previously called the Custom Formulary), but provides lower cost and better value for our customers' health care dollars.

Several drugs and drug categories will be excluded from coverage under the new benefit. These include the following:

- Brand-name drugs that have generic equivalents
- Over-the-counter medications (unless considered preventive by the United States Preventive Services Task Force)
- Lifestyle drugs (drugs used for erectile dysfunction or weight loss)
- Cosmetic drugs
- Drugs used for coughs and colds
- Most nonsedating antihistamines
- Most proton pump inhibitors, except select generic versions
- Prenatal vitamins
- Compounded drugs, with some exceptions

NHR DRUG continued on Page 31

NHR DRUG continued from Page 30

In addition to the changes in coverage, BCBSM and BCN small group and individual members will see a change in their copayment structure. BCBSM members will have either a three-tier or five-tier drug benefit, while BCN members will have a six-tier drug benefit. This applies to all members who enroll through the Health Insurance Marketplace, those who purchase directly from the Blues or members whose employers choose the new, less expensive Custom Select Drug List.

Below is a description of our new prescription benefit structure that we'll use for the Custom Select Drug List.

Tier 1: Generics — Lowest drug copayment
All drugs in this category are generic drugs. Members pay the lowest copayment for generics, which makes them the most cost-effective options for treatment. BCN groups generic drugs into two tiers:

- Tier 1A (lowest generic copayment) includes preferred generic drugs to treat chronic diseases like high blood pressure, high cholesterol, diabetes, heart disease, certain eye diseases, depression and congestive heart failure.
- Tier 1B (highest generic copayment) includes other covered generic drugs.

Tier 1A and 1B only apply to BCN. BCBSM covers generic drugs at a Tier 1 copayment.

Tier 2: Preferred Brand — Higher copayment
This category includes preferred, brand-name drugs. These drugs are more expensive than generics, and you'll pay a higher copayment for them.

Tier 3: Nonpreferred Brands — Highest brand-name copayment
In this category are nonpreferred brand-name drugs for which there is either a generic alternative or a more cost-effective preferred brand. You will pay the highest nonspecialty drug copayment for these medications.

Tier 4: Preferred Specialty — Lowest specialty drug copayment
Specialty drugs in Tier 4 are generally more effective and less expensive than nonpreferred specialty drugs in Tier 5.

Tier 5: Nonpreferred Specialty — Highest specialty drug copayment
Members pay the highest copayment for specialty drugs in Tier 5. That's because there may be a more cost-effective generic or preferred brand available.

The new Custom Select Drug List will be available online by Jan. 1, 2014.

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 removes compounded hormones from commercial drug coverage

Effective Nov. 1, 2013, we will no longer cover compounded hormone products for members who have Blue Cross Blue Shield of Michigan commercial (non-Medicare) prescription drug coverage. Compounded drugs may expose members to risks from products that have not been tested for safety or effectiveness by the Food and Drug Administration.

This change is part of our ongoing efforts to promote cost-effective and high-quality prescription drug therapy.

BCBSM commercial members will no longer have compounded hormone products covered under their drug benefit plan. These products include compounds that contain any of the following ingredients:

- Estradiol
- Estrone
- Hydroxyprogesterone caproate
- Methyltestosterone
- Progesterone
- Testosterone

This does not apply to members who have Blue Care Network plans, BCBSM Michigan Education Special Services Association plans, BCBSM Medicare Advantage plans or Medicare Part D plans. We will notify affected members of these changes and encourage them to contact their physicians to discuss other treatment options, including commercially available, FDA-approved products on our drug lists.

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

DME

CPAP equipment providers must follow compliance rules

Durable medical equipment providers must follow certain compliance rules for providing continuous positive airway pressure devices to our members.

These rules specify that:

- Downloads and documentation are required for all CPAP set-ups, regardless of previous usage.
- The BCBSM member compliance form is required for all CPAP set-ups. You must have this form in each patient's record for audit review.
- You must collect compliance downloads for days 31 through 90 of a trial period to qualify for continued rental. The member's chart must show 70 percent compliance in using the CPAP device.
- Each new trial period, as outlined in the *Continuing Coverage Guidelines*, must be started with a physician order.

If any of this documentation is missing from your file during an audit, the entire rental and subsequent supplies can be denied for a lack of documentation or medical necessity.

AUTOS

Blue Cross to manage DME and P&O claims processing, customer service for auto group customers, URMBT members

Starting Jan. 1, 2014, Blue Cross Blue Shield of Michigan will begin managing benefits for our auto group customers and UAW Retiree Medical Benefits Trust members who use durable medical equipment and prosthetics and orthotics services.

Our current DME and P&O vendors will no longer handle claims processing and customer service for our General Motors, Chrysler, Ford and URMBT members. These vendors include DMEnsion Benefit Management and Northwood, Inc., which operate under the following program names:

- HME National Network
- SUPPORT
- Northwood National Provider Network

For the remainder of the year, auto group customers and URMBT members should continue using their current DME and P&O suppliers. Claims for services rendered before Jan. 1, 2014, should be submitted to the appropriate vendor.

Beginning Jan. 1, 2014, members will need to use suppliers who have a contract with their Blue Cross and Blue Shield plan. Participating DME and P&O providers that offer services to our auto group customers and URMBT members on or after Jan. 1, 2014, should bill the members' local Blue plan. If a supplier ships medical supplies out-of-state to a member, then that supplier must participate with the Blue plan in the member's state for the member to receive his or her full benefits.

In addition, Michigan providers are reminded that accrued rental payments for DME items used under the member's vendor program should be counted toward the Blue Cross-approved purchase price for those items. For more information, see the article on DME rentals in the October *Record*.

Keep in mind that Blue Cross will honor current prescriptions for rental DME and medical supplies as long as the supplier remains the same, the prescription is still valid and it covers the rental period for equipment or supplies being billed.

Starting in mid-November, members who receive life-sustaining equipment (such as oxygen tanks and dialysis equipment) from nonparticipating suppliers will get outreach assistance. A specialist in our Wellness and Engagement area may reach out to you to help members transition to a participating supplier.

This change does not apply to Blue Care Network, the State of Michigan and Michigan Public School Employee Retirement System, which will continue using the SUPPORT program and NNPN after Jan. 1, 2014.

Please contact your BCBSM provider consultant if you have any questions.

Sequestration fee reductions for Medicare Advantage professional providers

As a result of the reimbursement reductions at the federal Centers for Medicare & Medicaid Services due to the budgetary sequestration, Blue Cross Blue Shield of Michigan will implement a 0.5 percent payment reduction effective Jan. 1, 2014. This is in addition to the current 2 percent payment reduction.

The original 2 percent sequestration reduction was planned for implementation by April 1, 2013. However, based on our provider contractual agreements, BCBSM is required to provide a 90-day notice before initiating these types of changes. Therefore, our sequestration reduction wasn't implemented until July 1, 2013.

To offset the 90-day delay in implementation, we will increase the sequestration reduction by 0.5 percent, effective Jan. 1, 2014.

This sequestration reduction applies to the paid amount for both network and non-network providers. Further details are included in the applicable provider network agreements.

If there are no further changes in CMS guidance, the 0.5 percent reduction will be discontinued on Dec. 31, 2014.

This information was also detailed in a Sept. 30, 2013, web-DENIS message.

Questions about this reimbursement reduction can be directed to your BCBSM provider consultant.

New procedure code added to Medicare Advantage physician office lab list

Blue Cross Blue Shield of Michigan has added procedure code *83861 to our Medicare Advantage Physician Office Laboratory list. This procedure code is payable in an office setting when it's performed by an optometrist or ophthalmologist. We hope this addition will support your patient care.

This test is covered by Medicare and other third-party payers when it's medically necessary and ordered by a licensed provider. It's covered and reimbursed as a lab service under the federal Clinical Laboratory Improvement Amendments Act.

For more information, please see the Sept. 25 web-DENIS message on this topic or contact your provider consultant.

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

Vision and hearing providers

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

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

Provider Consulting Services, Manager's Office

Southeast Michigan	313-225-7778 (professional) 313-225-0914 (facilities)
West Michigan	616-389-8141
Mid Michigan	517-324-4590
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

Corporate Communications – MC 0245

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, Michigan 48226-2998

ADDRESS SERVICE REQUESTED

bcbsm.com

Visit our website at:
bcbsm.com

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

Managing Editor .....Joe Lieblang
ProvComm@bcbsm.com

Layout.....Patsy A. Wheatley

To subscribe to receive *The Record* via email, 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*.
- Scroll to the bottom and click on the *Subscribe* button.